INSPECTION OF CARE
INTERPRETATIVE GUIDELINES
INCLUDING PERTINENT
ILLINOIS ADMINISTRATIVE CODE RULES
FOR
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

BUREAU OF LONG TERM CARE
ILLINOIS DEPARTMENT OF PUBLIC AID

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INTRODUCTION

The Inspection of Care (IOC) interpretative guidelines have been developed as a reference and working tool for staff of the Illinois Department of Public Aid and participating providers of skilled nursing facility (SNF) and intermediate care facility (ICF) services within the State. It is used by case management staff of the Bureau of Long Term Care when conducting the IOC in SNFs and ICFs.

The IOC, is conducted to determine the need for and adequacy of long term care facility services provided to Medicaid residents.

Material in this document is divided into six sections. The first section, Section B, is facility and resident information. It is not scored and has no reimbursement component.

Section C rates functional and restorative levels of care, frequently referred to as "activities of daily living." It is scored for all residents and does have a reimbursement component.

Section D rates service needs and has a reimbursement component. Services are measured in terms of frequency or intensity and evaluated on the day of the survey unless a different time frame is specified for that particular service. Intensity is measured in terms of the type of nursing staff primarily or solely responsible for providing the service. Uncomplicated services may be provided by unlicensed personnel under licensed supervision. More complex service or services provided for residents with conditions requiring more skilled care can be provided only by licensed staff.

Section E is Social Services. This section addresses resident's rights, resident's councils, resident's accounts, social histories and the provision of age appropriate activities and opportunities to pursue activities consistent with the resident's interest. These services are reimbursed in the base rate but the adequacy of the services are scored in Section D.

Section F is the summary section for the preceding sections including recommendations, the number of physician referrals and items to be arbitrated.

The sixth and final section is F which is for the signatures and titles of IDPA staff conducting the survey.

Appendix A is definitions of commonly used terms in the IOC. Appendix B is further indicators for measurement of progress for occupational and physical therapy, speech language pathology and audiology rehabilitative services.

Data collected from the Medicaid resident's clinical record and supported by personal contact and observation of the resident and/or service delivery is used in scoring and completing Form DPA 2700, Illinois Assessment of Need for Care, for each resident.

Completed Forms 2700 not only support the Department's responsibility for utilization control but provide data used in establishing the facility's nursing reimbursement rate.

SECTION A: PERSONAL INFORMATION

INSTRUCTIONS: Items 1-10 contain personal information for each resident. Print names, addresses, ID and dates according to specifications below.

ITEM	CODING SPECIFICATIONS	AGENCY NOTE
1.	FACILITY NAME	PRINT FACILITY NAME OR USE FACILITY STAMP IF AVAILABLE
2.	FACILITY ID NUMBER	9 DIGIT FACILITY ID NUMBER (IDPH)
3.	FACILITY ADDRESS	CITY/COUNTY
4.	PROVIDER ID NUMBER	12 DIGIT PROVIDER NUMBER (FEIN)
5.	RESIDENT'S NAME	LAST NAME, FIRST NAME, MIDDLE INITIAL
6.	RECIPIENT'S ID NUMBER	IDPA COUNTY CODE NUMBER (3 DIGIT)/ FOLLOWED BY ONE SPACE THEN THE IDPA (9 DIGIT) RECIPIENT IDENTIFICATION NUMBER (RIN).
7.	RESIDENT'S DATE OF BIRTH	MONTH/DAY/YEAR, MUST BE A SIX (6) DIGIT NUMBER, i.e., 01/01/85.
8.	RESIDENT'S ADMISSION DATE	MONTH/DAY/YEAR, MUST BE A SIX (6) DIGIT NUMBER, i.e., 01/01/85.
9.	PHYSICIAN'S NAME	ATTENDING PHYSICIAN'S COMPLETE NAME
10.	DIAGNOSIS	COMPLETE DIAGNOSIS: WRITTEN OR ICD-9-CM CODE.

SECTION A: PERSONAL INFORMATION

INSTRUCTIONS: Items 11-14 contain personal information for each resident. Circle Y (Yes) or N (No) as appropriate. Each item must be completed.

AGENCY

ITEM	CODING SPECIFICATIONS	NOTE
11.	PLAN OF CARE	Y = The plan of care is up-to-date according toadmission, the time frame: physician initially establishes the plan of care through the history,
a)	SNF - a physician and facility personnel must review each plan at least every 90 days or as needed. objectives, orders	physical exam, functiona level and plans for continuing care and discharge. This includes the resident care plan.
		N = The plan of care is not up-to-date.
b)	ICF - a physician and facility personnel must review the plan at least every 90 days or as needed.	
12.	PHYSICIAN'S CERTIFICATION/ RECERTIFICATION/ NOTE: See Form DPA 2448, Physician Certification or an alternate form. If an alternative used, location of certification must be documented on DPA 2448.	Y = The physician certified at the time of admission and recertified according to the time frame in the medical record. If items 11-14 are marked “N”, make a facility referral.
		N = Resident not initially certified or recertified at required intervals.
a)	SNF - 30/60/90 days after initial certification, and every 60 days thereafter.	
b)	ICF - 60 days/180 days/12 months/ /18 months/24 months after initial certification, every 12 months there-after.	
c)	ICF/DD - every 12 months after initial certification.	
a)	Certification if after the date of admission and if no eligible date is on 2448; or	
b)	Eligible date is before signature date; or	
c)	No Recipient Identification Number and/or no Case Identification Number.	

3-1-91

SECTION A: PERSONAL INFORMATION

INSTRUCTIONS: Circle codes 1 or 2 as appropriate under each item. ITEMS 10-12 SHOULD BE EVALUATED PRIOR TO EVALUATING ITEM (9) PLAN OF CARE.

AGENCY

ITEM	CODING SPECIFICATIONS	NOTE
13.	PHYSICIAN'S PROGRESS NOTES/ VISITS	Y =Progress notes for skilled care must be updated once every 30 days for the first 90 days following admission. After the first 90 day period has passed, an alternate review schedule may be adopted. Alternate review schedules of progress notes must not exceed 60 days. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Y =Progress notes for intermediate care must be updated once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. N = Progress notes not updated within required intervals listed above.
14.	PHYSICIAN'S MEDICATION REVIEW	Y =Physician has reviewed medications within the last 30 days for SNF and 90 days for ICF residents. N =Physician has not reviewed medications at required intervals.

8-31-92

RULE

SECTION B: COMPREHENSIVE RESIDENT ASSESSMENT

A) Type Code: Frequency Codes

1) Two or more full comprehensive assessments were necessary and completed in the past year (based upon admission date or completion date of the last full comprehensive assessment). The interdisciplinary team must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

SECTION B: COMPREHENSIVE RESIDENT ASSESSMENT

BASE RATE SERVICES

One comprehensive resident assessment followed by quarterly reviews has been completed within the past year.

VERIFICATION OF LEVEL OF SERVICE

* A comprehensive resident assessment must be completed within fourteen days of admission; or, in the case of a significant change in resident condition, as soon as the resident stabilizes at a new functional or cognitive level or within 14 days, whichever is earlier and must be repeated no less often than every 12 months from the date of the last full comprehensive resident assessment. A comprehensive care plan must be developed within 7 days of completion of the comprehensive resident assessment and updated every 90 days or sooner if the resident has experienced a significant change in status. The interdisciplinary team must examine each resident no less than once every 90 days, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment. A resident would score on this level if two or more full comprehensive assessments were necessary and completed in the past year because of a significant change in the resident condition.

NEED NOT MET

* Comprehensive resident assessment not completed within fourteen days of admission; or, in the case of a significant change of condition, as soon as the resident stabilizes at a new functional or cognitive level or within 14 days, whichever is earlier.
* Comprehensive resident assessment not completed within 12 months from the date of the last comprehensive resident assessment.
* Care plan not developed by interdisciplinary team within 7 days of completion of the comprehensive resident assessment or care plan not updated every 90 days or sooner if the resident has experienced a significant change in status.
* Comprehensive resident assessment not reviewed and updated at least quarterly as indicated by date and signature of person completing the quarterly review.
* The assessment process is not coordinated by a registered nurse, as indicated by date and signature on comprehensive assessment.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

SECTION B: COMPREHENSIVE RESIDENT ASSESSMENT

AGENCY NOTE

* Nursing home residents admitted prior to October 1, 1990, are required to have a minimum data set comprehensive assessment completed before October 1, 1991. IOCs which take place between January 1, 1991 and October 1, 1991, which include residents admitted prior to October 1, 1990 that have not yet had a minimum data set comprehensive resident assessment are to be scored "0" with no Need Not Met given.
* Reassessment must be consistent with observation, interview, progress notes and care plan.
* Interdisciplinary team shall include:
  . Resident, resident's family and/or legal representative and/or guardian
  . Attending Physician
  . Registered nurse
  . Licensed nurse responsible for resident
  . Social Service staff, and
  . other appropriate staff in disciplines as determined by the resident's needs; such as, activity staff, dietary staff, direct care Certified Nurses' Aides and rehabilitation personnel.
* A "significant change" means any of the following:
  . Deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear permanent. For example, simultaneous functional and cognitive decline often experienced by residents with chronic, degenerative illness such as Alzheimer's Disease or pronounced functional changes following a stroke.
  . Loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself, such as, spoon, toothbrush, or comb. Such losses must be permanent and not attributable to identifiable, reversible causes such as drug toxicity from introducing a new medication, or an episode of acute illness such as influenza.
  . Deterioration in behavior, mood, and/or relationships where staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention.
  . A serious clinical complication.
  . A new diagnosis of a condition that is likely to affect the resident's physical, mental or psychosocial well-being over a prolonged period of time.
  . Onset of a significant weight loss or weight gain (5% in one month, 7.5% in three months, 10% in six months or a continuous weight loss or gain over six months) which is not a care plan goal.

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

SECTION B: COMPREHENSIVE RESIDENT ASSESSMENT

AGENCY NOTE

. Deterioration in a resident's health status, where this change: places the resident's life in danger, e.g., stroke, heart condition, or diagnosis of metastatic cancer; is associated with a serious clinical complication, e.g., initial development of a stage III or stage IV pressure ulcer, the initial onset of non-relieved delirium, or recurrent loss of consciousness; or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, e.g., Alzheimer's Disease or diabetes.
. A marked and sudden improvement in the resident's status, for example, a comatose resident regaining consciousness.

Document in progress notes the initial identification of a significant change in status.

Once the interdisciplinary team determines the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of this determination.

* Do not assess the resident if declines in a resident's physical, mental, or psychosocial well-being are attributable to:

. Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level.
. Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect full recovery of the resident's pre-morbid functional abilities and health status.
. Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease.

* The facility may amend assessment information collected during the fourteen days post-admission period up until the 21st day after admission, if any of the following three circumstances occur:
. Staff have no way to complete an item by the fourteenth day because information is not available.
. Further observation and interaction with the resident reveals the need to alter the initial assessments in any of the following MDS domains: cognitive patterns; communication patterns; potential for self-care improvement/rehabilitation; psychosocial well-being; mood and behavior patterns; and activity pursuit patterns.
. Upon admission, the resident's condition is unstable because he/she is experiencing an acute illness or flare-up of a chronic problem and the acute illness or chronic problem is controlled by the 21st day.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 1 - BATHING/GROOMING

FUNCTIONAL AREA

1. Needs and receives hands-on assistance due to functional deficit(s) (as determined by physical or psychological causes). Resident is helped with bathing some part of her or his body. This includes oral hygiene, washing hair and shaving.

2. Totally dependent. Resident requires and receives total assistance from staff with bathing due to a functional deficit(s) (as determined by physical or psychological causes). Resident is bathed by a staff person whether the bath is given in the tub, shower, or bed.

RESTORATIVE

1. Bathing and Grooming - Staff has developed and is implementing a specific program to assist resident to improve functional abilities in bathing and grooming due to a functional deficit(s) (as determined by physical or psychological causes).

MAINTENANCE

2. Restorative care and program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and program intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

AGENCY NOTE

* An assessment should be completed identifying the resident current level of functioning in bathing and grooming. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.
* Prior to a resident being given credit for restorative care in any program, the following must be met:
  . An assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course.
  . A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
  . Program must be reflected in the resident's care plan.
  . Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
  . The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided. (The care plan review is required by 42 CFR 483.20 (1990).

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 1 - BATHING/GROOMING

BASE RATE SERVICES

* General reminders of when to take a bath.
* Assistance with combing/brushing hair or assistance with washing back.
* One-to-one verbal instruction.

FUNCTIONAL AREA VERIFICATION OF LEVEL OF SERVICE

* Kardex or flowsheet or care plan.
* Observation of resident to determine overall functional ability.
* Observation of 5-12 residents during bathing to determine level of assistance provided.
* Need for hands on assistance must be supported by assessment/reassessment.

NEED NOT MET

* Following supplies are not available and or the facility does not have a method of identifying individual resident supplies. Resident supplies are not stored in a sanitary manner:
  . Toothbrush and paste.
  . Comb.
  . Denture supplies if appropriate.
  . Shavers or razors.
  . Washcloth and towels.
  . Soap.
* Facility does not have available:
  . Clippers or scissors for nail care.
  . Individualized deodorants.
  . Shampoos.
* Equipment is not:
  . In good repair.
  . Clean.
  . Sanitized between resident use.
  . Used, as evidenced by resident's appearance.

*Resident has:
  . Dirty or untrimmed nails.
  . Dirty or uncombed hair.
  . Body odor.
  . A dirty body, includes earwax build up, foreign matter crusted on eyes or mouth, etc.
  . Lack of oral hygiene.
  . Not been shaven (see Agency Note).

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 1 - BATHING/GROOMING

AGENCY NOTE

* Consider the time of day, i.e. right after a meal a resident may not be as clean as early morning.
* If the Case Manager determines the documented level of bathing assistance required by the facility staff is incorrect in more than 25% of the residents checked for verification, the Case Manager will have to check more residents for verification. (All residents in the facility may have to be checked if the facility does not give accurate information).
* If resident is not shaved due to personal preference, it should be noted in the Kardex or care plan.
* Odor related to a medical condition or untreatable cause, should not be marked NEED NOT MET, so long as the problem has been identified. The problem is documented in the clinical record and there is an appropriately implemented treatment plan to correct or alleviate the condition.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 1 - BATHING/GROOMING

RESTORATIVE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEED NOT MET

* No assessment/reassessment in the last 90 days.
* Goals met and new goals not established.
* Restorative intervention not implemented as specified in the care plan.
* Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course), and clinical record and care plan do not indicate staff is addressing the lack of progress.
* Licensed staffs' notations of the resident's response is not documented at least monthly in the clinical record.

AGENCY NOTE

* Clinical record may include any type of interdisciplinary team documentation, i.e. treatment report, flowsheet, etc.
* Assessment should address:
  . Identification of resident's strengths and potential.
  . Identification of resident's deficit areas and causes.
  . Strengths/deficits should be stated in specific terms.
* Restorative program should address steps of program reflected in care plan.
* Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.
* If resident fails to increase his/her functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.
* Progress should be noted by objective documentation indicating increase in resident's functional level.
* Restorative programs must be integrated into the resident's daily care except when contraindicated at which time the program should be revised.
* Resident must receive Level 1 or 2 services to qualify for a corresponding ADL restorative program.

3-1-91

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INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 1 - BATHING/GROOMING

RESTORATIVE MAINTENANCE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEEDS NOT MET

* No assessment/reassessment in the last 90 days.
* Restorative intervention not implemented as specified in the care plan.
* Licensed staffs' notation of the resident's response not documented at least monthly in the clinical record.
* Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.

AGENCY NOTE

* A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 2 - CLOTHING

FUNCTIONAL AREA

1. Needs and receives hands-on assistance due to a functional deficit(s) (as determined by physical or psychological causes). Resident requires and receives help when getting dressed. This involves the actual assisting with putting on clothes.

2. Totally dependent. Resident requires and receives total assistance due to a functional deficit(s) (as determined by physical or psychological causes) from staff with dressing. Resident is dressed by a staff person and does not participate in dressing of self. This includes bedfast residents being dressed in gown, pajamas, etc..

RESTORATIVE

1. Clothing - Staff has developed and is implementing a specific program to assist resident to improve functional abilities in dressing due to a functional deficit(s) (as determined by physical or psychological causes).

MAINTENANCE

2. Restorative care and program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

AGENCY NOTE

* An assessment should be completed identifying the resident current level of functioning in dressing. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

* Prior to a resident being given credit for restorative care in any program, the following must be met:
  . An assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course.
  . A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
  . Program must be reflected in the resident's care plan.
  . Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
  . The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided. (The care plan review is required by 42 CFR 483.20 (1990).

8-31-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 2 - CLOTHING

BASE RATE SERVICES

* Assistance in choosing appropriate clothing.
* Verbal reminders to dress.

FUNCTIONAL AREA
VERIFICATION OF LEVEL OF SERVICE

* Kardex or flowsheet or care plan.
* Observation of resident to determine overall functional ability.
* Observation of 5-12 residents during dressing to determine level of assistance provided.
* Need for hands on assistance must be supported by assessment/reassessment.

NEED NOT MET

* When resident is:
  . Not wearing clothing that is clean, odor-free, in good repair, well fitting, appropriate to the season, time of day and condition of the resident.
  . Not wearing underwear, unless contraindicated.
  . Not wearing socks, unless contraindicated.
  . Not wearing shoes or slippers, unless contraindicated.
  . Wearing clothing visibly marked with name.

AGENCY NOTE

* If shoes or slippers are unable to be worn due to physical disability or physician's orders, this must be documented on the Kardex or the care plan.
* Consider time of day, i.e. at 4:00 p.m. clothing may not be as clean as at 8:00 a.m.

3-1-91

CATEGORY 2 - CLOTHING

AGENCY NOTE (CONT.)

* If underwear is contraindicated this must be documented on the Kardex or the care plan.

RESTORATIVE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to insure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEED NOT MET

* No assessment/reassessment in the last 90 days.
* Goals met and new goals not established.
* Restorative intervention not implemented as specified in the care plan.
* Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course) and the clinical record, and care plan does not indicate staff addressing the lack of progress.
* Licensed staffs' notations of the resident's response not documented at least monthly in the clinical record.

AGENCY NOTE

* Clinical record may include any type of interdisciplinary team documentation, i.e. treatment report, flowsheet, etc.
* Assessment should address:
  . Identification of resident's strengths and potential.
  . Identification of resident's deficit areas and causes.
  . Strengths/deficits should be stated in specific terms.
* Restorative program should address steps of program reflected in care plan.
* Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.
* Progress should be noted by objective documentation indicating increase in resident's functional level.
* If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.
* Resident must receive Level 1 or 2 services to qualify for a corresponding ADL restorative program.

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CATEGORY 2 - CLOTHING

AGENCY NOTE (CONT.)

* Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program should be revised.

RESTORATIVE MAINTENANCE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEEDS NOT MET

* No assessment/reassessment in the last 90 days.
* Restorative intervention not implemented as specified in the care plan.
* Licensed staffs' notation of the resident's response not documented at least monthly in the clinical record.
* Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.

AGENCY NOTE

* A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of ADL.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 3 - EATING

FUNCTIONAL AREA

1. Resident needs and receives hands-on staff assistance due to functional deficit(s) (as determined by physical or psychological causes) to eat some part of the meal.

2. Totally dependent. Resident requires and receives total assistance due to a functional deficit(s) (as determined by physical or psychological causes) from staff with eating.

3. Tube Feeding. Resident requires and receives tube feeding. Resident is fed through nasogastric tube or gastrostomy tube regardless of other oral food intake.

RESTORATIVE

1. Eating - Staff has developed and is implementing a specific program to assist resident to improve functional abilities in eating due to a functional deficit(s) (as determined by physical or psychological causes).

MAINTENANCE

2. Restorative care and program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

AGENCY NOTE

* An assessment should be completed identifying the resident current level of functioning in eating. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

* Prior to a resident being given credit for restorative care in any program, the following must be met:
  . An assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, a registered nurse who has successfully completed an approved rehabilitation course, or a speech language pathologist.
  . A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
  . Program must be reflected in the resident's care plan.
  . Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
  . The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his/her functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided. The care plan review is required by 42 CFR 483.20 (1990).

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INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 3 - EATING

BASE RATE SERVICES

* Routine tray preparation
  . Opening milk cartons
  . Cutting food
  . Pouring coffee/beverages
  . Buttering bread

* Verbal reminders to eat (encouragement)

FUNCTIONAL AREA
VERIFICATION OF LEVEL OF SERVICE

* Kardex or flowsheet or care plan.
* Observation of resident to determine overall functional ability.
* Observation of all residents to assure staff is providing assistance as indicated in the Kardex and/or flowsheet and/or care plan.
* Physician order for tube feeding:
* Need for hands on assistance must be supported by assessment/reassessment.

NEED NOT MET

* Does not receive the assistance as indicated in the Kardex or flow sheet or care plan or as indicated by observation of the resident.
* Does not receive diet as ordered, including snacks as scheduled.
* Does not have adaptive devices available, if indicated in on Kardex and/or flowsheet and/or care plan, i.e. plate guards, built-up spoons and forks and clothing protectors. Adaptive devices are not used appropriately as indicated in the clinical record.
* Fluids not offered and/or accessible to residents between meals.
* Food not served at appropriate temperature; i.e. warm foods not served warm and cold foods are not served cold as evidenced by resident's response/verbalization and as confirmed by case manager observation.
* Food appropriate utensils not provided/available.
* Facility protocol for weighing residents not followed.
* Facility not following its own protocol and/or written procedures for tube feedings.
* Weight loss or gain of 5% in one month, 7.5% in three months, 10% in six months or a continuous weight loss or gain over six months not reported to the physician.
* Plan for corrective action regarding weight loss or gain not developed or implemented, as per physician order.
* Protocols not available or followed for tube feeding.
* Tube feeding not rendered by licensed personnel.
* Equipment for tube feedings is soiled or improperly maintained.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 3 - EATING

AGENCY NOTE

* Protocol must address safety, infection control procedures, I & O, frequency of weighing and should outline steps of tube feeding procedures. If protocol is in question, refer to team Physician Consultant.

RESTORATIVE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist or a speech language pathologist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to insure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEED NOT MET

* No assessment/reassessment in the last 90 days.
* Goals met and new goals not established.
* Restorative intervention not implemented as specified in the care plan.
* Resident not meeting goal(s) (established by the physical therapist, occupational therapist, speech language pathologist or registered nurse who has successfully completed an approved rehabilitation course) and the clinical record, and care plan does not indicate staff is addressing the lack of progress.
* Licensed staffs' notations of the resident's response not documented at least monthly in the clinical record.

AGENCY NOTE

* Clinical record may include any type of interdisciplinary team documentation, i.e. treatment report, flowsheet, etc.
* Assessment must address:
  . Identification of resident's strengths and potential.
  . Identification of resident's deficit areas and causes.
  . Strengths/deficits must be stated in specific terms.
* Restorative program must address steps of program-reflected in care plan.
* Restorative programs are limited to residents who cannot perform functional tasks, but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.
* If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.
* Progress by objective documentation indicating increase in resident's functional level.
* Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program must be revised.
* Resident must receive Level 1 or 2 services to qualify for a corresponding ADL restorative program.

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 3 - EATING

RESTORATIVE MAINTENANCE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist, a registered physical therapist or a speech language pathologist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEEDS NOT MET

* No assessment/reassessment in the last 90 days.
* Restorative intervention not implemented as specified in the care plan.
* Licensed staffs' notation of the resident's response not documented at least monthly in the clinical record.
* Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, speech language pathologist or registered nurse who has successfully completed an approved rehabilitation course.

AGENCY NOTE

* A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of ADL.

8-31-92

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 4 - MOBILITY

FUNCTIONAL AREA

1. Needs and receives hands-on assistance due to a functional deficit(s) (as determined by physical or psychological causes) with standing, transfer or movement about the facility. Resident can ambulate or move about facility per self once transfer is completed. Or, resident can transfer independently, but staff must assist resident with movement about the facility.

2. Resident requires and receives hands-on assistance due to a functional deficit(s) (as determined by physical or psychological causes) to transfer from bed to chair or wheelchair and requires and receives assistance with movement about the facility.

RESTORATIVE

1. Mobility - Staff has developed and is implementing a specific program to assist resident to improve functional abilities in transferring, ambulation, wheelchair mobility, and/or bed mobility due to a functional deficit(s) (as determined by physical or psychological causes).

MAINTENANCE

2. Restorative care and program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

AGENCY NOTE

* An assessment should be completed identifying the residents current level of functioning in bed mobility, transfer and locomotion. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 4 - MOBILITY

AGENCY NOTE

* Prior to a resident being given credit for restorative care in any program, the following must be met:
  . An assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course.
  . A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
  . Program must be reflected in the resident's care plan.
  . Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
  . The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided. (The care plan review is required by 42 CFR 483.20 (1990).

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 4 - MOBILITY

BASE RATE SERVICES

* Repositioning for comfort.
* Supervision of ambulatory residents.
* Redirection of lost and/or wandering residents.
* Reminders to use handrails.
* Reminders to use assistive devices correctly.
* Residents who are totally bedfast.
* Assistance in and out of bathtub or shower.

FUNCTIONAL AREA
VERIFICATION OF LEVEL OF SERVICE

* Kardex or flowsheet or care plan.
* Observation of residents to determine overall functional ability and if wheelchair, walkers, or other assistive devices are available and used.
* Residents should be observed being assisted by facility staff, as needed.
* Need for hands on assistance must be supported by assessment/reassessment.

NEED NOT MET

* Resident who is not able to change position independently has not been exercised or ambulated, and repositioned every 2 hours.
* Resident is not positioned properly.
* Assistive device is not in proper working order, and/or clean or well fitting i.e. walker, cane, wheelchair, etc.
* The facility does not have, or is not implementing, a plan for monitoring a resident who is unable to use the call bell or the call bell is not within reach of a resident in his or her room who can use the call bell.
* Resident needs and does not have assistive device as ordered by a physician.
* Staff do not respond when summoned by a resident for help or assistance.
* Not following physician order on bed rest.

AGENCY NOTE

* Residents who are totally bedfast will be scored Level 0 for mobility.
* If resident is unable to use call bell, care plan or Kardex must indicate staff plan for monitoring resident.
* Bedrest is an order by physician that resident is to be in bed at all times, except up at intervals of no more than one hour up to three times a day, i.e. for meals in room. Scoring will be according to the assistance required and provided.

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 4 - MOBILITY

RESTORATIVE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEED NOT MET

* No assessment/reassessment in the last 90 days
* Goals met and new goals not established.
* Restorative intervention not implemented as specified in the care plan.
* Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course) the clinical record, and care plan does not indicate staff is addressing the lack of progress.
* Licensed staffs' notations of the resident's response is not documented at least monthly in the clinical record.

AGENCY NOTE

* Clinical record may include any type of interdisciplinary team documentation, i.e. treatment report, flowsheet, etc.
* Assessment should address:
  . Identification of resident's strengths and potential.
  . Identification of resident's deficit areas and causes.
  . Strengths/deficits should be stated in specific terms.
* Restorative program should address steps of program-reflected in care plan.
* Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.
* If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.
* Progress by objective documentation indicating increase in resident's functional level.
* Restorative programs must be integrated into the resident's daily care except when contraindicated at which time they should be revised.
* Resident independent in mobility due to assistive device may qualify for ADL restorative mobility program and PT when program is to assist resident to move to a less restrictive mode of ambulation otherwise an ADL must be scored a 1 or higher.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 4 - MOBILITY

RESTORATIVE MAINTENANCE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment completed by an R.N. who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

NEEDS NOT MET

* No assessment/reassessment in the last 90 days.
* Restorative intervention not being implemented as specified in the care plan.
* Resident is not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.
* Licensed nurses' notation of the resident's response is not documented at least monthly in the clinical record.

AGENCY NOTE

* A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 5 - CONTINENCE

Type Code: Intensity Codes

FUNCTIONAL AREA

1. Resident is incontinent of bladder and/or bowel (includes dribbling).

2. Resident is assisted to toilet as frequently as indicated by resident need.

   (See Agency Note regarding bowel and bladder retraining program.)

RESTORATIVE -

1. Staff has assessed, planned, implemented and monitored, according to individual need, a specific formalized program to assist resident to improve abilities in continence.

MAINTENANCE -

2. Restorative care and formalized program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

AGENCY NOTE

* An assessment should be completed identifying the resident current level of functioning in continence. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

* Prior to a resident being given credit for restorative care in any program, the following must be met:
  - An assessment completed by a registered nurse, identifying the resident's current level of functioning, the cause or contributing factors of current incontinence, and a plan developed to increase this level of functioning by the interdisciplinary team.
  - A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days, but can be conducted as frequently as needed based on outcome and response.
  - Program must be reflected in the resident's care plan and individualized to the resident.
  - Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
  - The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his/her ability, after initial improvement, credit will still be given as long as restorative care continues to be provided. (The care plan review is required by 42 CFR 483.20 (1990))

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 5 - CONTINENCE

BASE RATE SERVICES

* Stand by Assistance provided, including assisting with clothing, verbal cues, etc.

FUNCTIONAL AREA
VERIFICATION OF LEVEL OF SERVICE

* Assessment and care plan or assessment and Kardex.
* Observation of resident to determine overall functional ability.
* Staff should be observed toileting the resident as per resident assessment. (Level 2 Only)
* Staff's mechanism to identify resident's need to toilet. (Level 2 Only)
* Need for hands on assistance must be supported by assessment/reassessment.

NEED NOT MET

* Facility not following its own protocol for a bowel and bladder program.
* Resident is allowed to remain wet and/or soiled for prolonged periods of time as demonstrated by skin irritation, dried urine and/or feces stains in bed linen and/or clothing.
* Resident is not thoroughly cleaned after episode of incontinence as demonstrated by smell of urine/defecation on body and clothing.
* Resident found wet and/or soiled and remains wet and/or soiled thirty minutes after finding.
* Staff is not immediately responsive to resident's request for toileting.

AGENCY NOTE

* For the purpose of this item, Level 2 includes informal B & B programs. Level 2 scores include residents who dribble and are assisted to the bathroom.
* If unable to verify level of service through observation of residents being toileted, target 5-12 residents to determine if bed and/or clothing is wet, soiled or if odor of urine or feces is present.
* Assessment as indicated means focusing on the portion of the previously completed overall resident assessment which indicates the resident's bowel and bladder capabilities. The assessment reflects the current needs of the resident.
* Give zero score for resident who dribbles and changes own continence pads.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 5 - CONTINENCE

RESTORATIVE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the residents functional level utilizing interdisciplinary approaches.
* Observation of the program to insure that plan is being implemented as specified in the care plan and is individualized to the resident needs.
* Monthly documentation of resident response by licensed staff or co-signed by licensed staff.

NEED NOT MET

* No assessment/reassessment within 90 days.
* Goal met and new goal not established.
* Restorative intervention not implemented as specified in care plan.
* Resident not meeting goal(s) established by the interdisciplinary team and the clinical record and care plan does not indicate staff is addressing the lack of progress.
* Staff notations of the resident response to the program is not documented at least monthly in the clinical record.
* Not following facility protocol.
* Has not established facility protocol.

AGENCY NOTE

* Clinical record may include any type of interdisciplinary team documentation, i.e. treatment report, flowsheet, etc.
* Assessment addresses:
  . Identification of residents deficit areas and causes such as:
    . medications
    . mental status
    . ability to control urine
    . self care abilities
    . mobility
    . voiding/elimination patterns/hydration baseline
    . history of urinary tract infection
  . Strengths and deficits should be stated in specific terms.
* Facility protocol should include types of incontinence, assessment, plan, implementation measures, evaluation techniques, staff training and monitoring.
* Restorative program and approaches should be reflected in the care plan.
* Restorative programs are limited to residents whose assessment has determined that there is a reasonable likelihood of increasing his or her functional level.
* If resident, after initial improvement, fails to continue to increase his/her functional ability, credit will still be given as long as restorative program continues to be carried out (Level 2 Maintenance).
* Progress should be noted by objective documentation indicating increase in resident's functional level as compared to initial baseline and/or most recent assessment.
* Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program should be revised.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 5 - CONTINENCE

AGENCY NOTE

* Resident must be scored a Level 2 (in functional area) in order to qualify for a corresponding ADL Restorative Continence program.
* The formal program must include, but is not limited to, the following:
  . training/counseling
  . voiding and elimination pattern records
  . toileting
  . hydration
* The training program does not have to be hands on assistance.
* Give zero score for formal bowel and bladder program if facility is not following its own protocol.

RESTORATIVE MAINTENANCE
VERIFICATION OF LEVEL OF SERVICE

* Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the residents functional level utilizing interdisciplinary approaches.
* Observation of this program to ensure plan as specified in the care plan is being implemented.
* Monthly documentation of resident response by licensed staff or co-signed by licensed staff.

NEEDS NOT MET

* No assessment/reassessment in the last 90 days.
* Restorative intervention not implemented as specified in the care plan.
* Staff notation of the resident's response to the program not documented at least monthly in the clinical record.
* Resident not meeting maintenance goal(s) established by the interdisciplinary team, unless the regression is justified and/or the facility has attempted alternative methods.
* Not following facility protocol.
* A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 6 - PSYCHOSOCIAL/MENTAL STATUS

1. Staff has developed and is implementing a specific intervention program that addresses psychosocial needs. This program is monitored by a QHP as evidenced by signing off on assessment and response notes, with written recommendations as appropriate in the clinical record. This program must be in the care plan and the resident's response to staff's intervention must be recorded in the clinical record at least monthly. Interventions may occur in 1:1 scheduled counseling sessions, group sessions no larger than eight, or strictly incident intervention. Incident intervention only programs are limited to residents with severe behavior problems which preclude participation in a more structured setting. Incident intervention only must consist of a plan with staff using ongoing specifically identified interventions for identified behavior occurrences. The plan may consist of any combination of the above-mentioned techniques. Interventions must take place at least three times a week.

AGENCY NOTE

* Prior to a resident program being given credit for psychosocial/mental status, the following must be met:
  . An assessment should be completed identifying the resident's current psychosocial status. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed or regressed. For episodic intervention, an assessment must include duration, intensity and frequency of behavior. The assessment for episodic behavior must also include precipitating factors and consequences.
  . A reassessment is conducted as indicated in the initial plan. A reassessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
  . A program must be reflected in the resident's care plan.
  . Staff carries out the program as indicated by the plan and records such in the clinical record at least monthly.
  . The program is reviewed at the time of the care plan meeting by the interdisciplinary team. (The care plan review is required by 42 CFR 483.20 (1990).

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY - 6 PSYCHOSOCIAL/MENTAL STATUS

BASE RATE SERVICES

* Occasional behavior intervention for that which the resident has not been assessed or for which no program has been implemented.
* Additional reminders for bathing, clothing, grooming and taking medicine.
* Explanations and assurances.
* Intervention/interaction with family.
* Reminders to attend activities.

VERIFICATION OF LEVEL OF SERVICE

* Observation of actual intervention, i.e. if group, observe group; if 1:1 counseling, observe session; if episodic intervention, observe if possible.
* Completed assessment identifying resident's current psychosocial needs.
* Staff assessing and implementing programs must be knowledgeable of the individual resident's current program.
* Care plan with specific intervention to address identified resident's needs with measurable objectives.
* Resident's response to care plan is documented in the clinical record monthly by staff responsible for the program.
* QHP is monitoring psychosocial program as evidenced by signing off on the assessment and response notes, with written recommendations as appropriate in the clinical record.
* Attendance sheets for scheduled 1:1 and group sessions.
* Program plan for scheduled 1:1 and group sessions.
* Episodic intervention and response to intervention is documented in the clinical record every other week.

NEED NOT MET

* Resident is not meeting goal(s) established by QHP or staff responsible for the program. Progress notes or care plan does not indicate staff is addressing the lack of progress.
* Care plan is not adhered to. The resident attended less than 85% of these sessions in the last three months and the clinical record does not indicate resident absence was due to illness or absence from the facility.
* Groups are larger than eight.
* Group programs or 1:1 have no program plan.
* Groups or 1:1 counseling meet less than three times a week.
* Documentation of resident's response to intervention is not in the clinical record every month for 1:1 and groups by staff monitoring the program.
* QHP is not monitoring psychosocial program as evidenced by absence of signing off on assessment and response notes and there are no written recommendations, as appropriate in the clinical record.
* Episodic intervention and resident response to the intervention is not documented every other week in the clinical record.
* The assessment for episodic behavior does not include the duration, intensity and frequency of behavior or the precipitating factors and consequences.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 6 - PSYCHOSOCIAL/MENTAL STATUS

AGENCY NOTE

* Psychosocial assessments and program plans must be completed by staff and signed off on by a QHP who have a working knowledge of the current psychosocial programs being implemented with the individual resident.

  Interview questions to the staff assessing and implementing programs would include, but are not limited to, the following:

  1. What program(s) is the resident on?
  2. Why is the resident in the program?
  3. What is the resident's goals(s)?
  4. What is your responsibility in implementing this program (interventions)?
  5. What is the resident's response to the intervention?
  6. If the goal is not achieved, what modifications have been made?

* If counseling occurs in groups, individuals must have similar problems and goals.
* Progress should be noted by objective documentation indicating an increase in functional capability and/or decrease in maladaptive behavior. These measurable objectives and goals should be clearly indicated on the resident's care plan.
* Programs consisting solely of episodic intervention should be reserved for resident with severe behavior problems that preclude participation in more structured programs.
* The care plan must be interdisciplinary with approaches as appropriate to the individual resident's need.

3-1-91

RULE

SECTION C: FUNCTIONAL NEEDS AND RESTORATIVE CARE

CATEGORY 7 - COMMUNICATION

Resident has been assessed, needs and receives special assistance or care as a result of altered sensory reception or transmission that involves visual, auditory or speech.

A) Type Code: Frequency Codes

1) Interventions are developed and implemented to address one communication deficit.

2) Interventions are developed and implemented to address two communication deficits.

3) Interventions are developed and implemented to address three communication deficits.

SPEECH THERAPY

A) General Criteria

1) There must be a reasonable likelihood that the treatment will improve the resident's functional means of communication. While there is no specific time limit on the duration of these services, improvement of the resident's condition must be evident in the therapist's documentation.

2) Specific Criteria

Resident requires and facility provides a Speech-Language Pathology and Audiology (SLP/A) Rehabilitative Program as ordered by a physician, planned and designed specifically for the resident by a certified speech-language pathologist/audiologist or Clinical Fellow (CFY) and including measurable goals. This program is carried out on a regularly scheduled basis by a certified speech-language pathologist/audiologist or Clinical Fellow (CFY). Progress notes are to be recorded as to the improvement of the resident's condition. This service must be reevaluated monthly by the certified speech-language pathologist/audiologist.

8-2-93

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 7 - COMMUNICATION

COMMUNICATION
VERIFICATION OF LEVEL OF SERVICE

* Assessment.
* Monthly response documented and co-signed by qualified health professional.
* Interventions developed and implemented by the interdisciplinary team.
* Interdisciplinary care plan interventions.
* Observation of interventions performed.

NEEDS NOT MET

* Staff not carrying out interventions as defined in interdisciplinary care plan.
* Clinical record does not indicate resident response to intervention monthly by qualified health professional co-signature.

AGENCY NOTE

* Approved appliances and assistive devices, including application and care of the appliance, are covered in the appliance category.
* Interventions must have a comprehensive, 7 day a week philosophy and must be implemented at each opportunity on a daily basis.
* Interventions must be monitored by interdisciplinary team.
* Staff should receive inservice training, as required.
* Interventions must be conducted on an individual resident basis.

SPEECH THERAPY
VERIFICATION OF LEVEL OF SERVICE

* Observation of treatment and monthly therapist review documentation. This review documentation must indicate progress.
* Assessment.
* Speech Pathologist's or Audiologist's treatment notes.
* Monthly reevaluation by the certified speech-language pathologist/audiologist.
* Physician order.

NEEDS NOT MET

* Plan is not implemented as specified by the therapist.
* Goals are not designed to increase resident's functional capabilities.
* Resident is not meeting goal(s) and clinical record does not indicate staff is addressing lack of progress.

8-2-93

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 7 - COMMUNICATION

AGENCY NOTE

* Speech-Language Pathology and Audiology Rehabilitative Program shall be planned and designed specifically for the resident by a certified speech-language pathologist/audiologist or Clinical Fellow.
* Progress must be noted by standard speech therapist/audiologist objective measures.
* Measurable goals must be designed to increase resident's functional means of communication and/or ability to swallow.
* Treatment sessions should be one-on-one; however, groups of two are acceptable if resident's goals and functional levels are similar.
* Refer to Appendix B for Speech Language Pathology/Audiology Rehabilitative Services Measurement of Progress.

8-2-93

RULE

SECTION D: SERVICE NEEDS

CATEGORY 1 - APPLIANCES

A) Type Code: Frequency codes

1) One or more appliance.

B) Appliances

Appliances restricted to the following devices, that the facility staff assist the resident with applying and/or maintenance/care of the appliance as indicated per physician's or dentist's orders and/or resident plan of care.

1) Hearing device (one or two)
2) Elastic joint supports
3) Ted or Jobst hose (one or two)
4) A neck brace
5) A back brace
6) Artificial limbs
7) Trusses (male and female)
8) Prescribed ACE bandages
9) Cervical collars
10) Slings
11) Contact lens
12) Artificial eye
13) Protective helmet
14) Cylinder braces
15) Eyeglasses
16) Dentures
17) Electrolarynx
18) Augmentative communication devices
19) Leg braces
20) Arm braces
21) Head braces
22) Splints
23) TENS Unit
24) Wheelchair cuffs
25) ADL adaptive equipment
26) Abductor bar/pillow
27) Self-release safety devices

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 1 - APPLIANCES

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Care plan or Kardex.
* Documentation must include:
  . Type of appliance
  . When to apply
  . Care/maintenance
* Observation of resident wearing appliance and indication that staff assists either with application and/or cleaning or maintenance.

NEED NOT MET

* Physician has ordered appliance and facility has not complied with physician order.
* Appliance is not in use as indicated by observation.
* Appliance does not fit properly.
* Appliance is dirty.
* Appliance is non-functional and clinical record does not indicate date of dysfunction or plans for correction.

AGENCY NOTE

* No physician order necessary for appliances resident has on admission, i.e. eyeglasses, dentures.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 2 - CATHETERIZATION

A) Type code: Intensity codes

1) Indwelling, Texas, suprapubic catheter, intermittent catheterization, including care and irrigation.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 2 - CATHETERIZATION

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Care plan or flowsheet or Kardex.
* Observation of resident noting type of catheter.
* Documentation must include:
  . Type of catheter
  . Care and maintenance
  . Frequency of intermittent catheterization
  . Output for indwelling catheter

NEED NOT MET

* Facility does not have protocols for catheterization and catheter care.
* Facility not following its own protocol or physician order for catheterization, catheter care or I & O.
* Signs of inflammation at insertion site or penile irritation from Texas catheter without clinical record reflecting date of observation; plan of care indicated.
* Tubing and/or bag improperly positioned and/or maintained.
* Urine sedimentation or urine not clear and clinical record does not indicate observation and subsequent plan of action.
* Catheterization rendered by non-licensed personnel.

AGENCY NOTE

* Protocol must address when intake or output is required.
* Protocol must address infection control.
* Intermittent catheterization means daily catheterization.
* Urine sedimentation would include blood, mucus and/or other matter.
* Leg bags can be applied by CNA trained in process when allowed by facility protocol.
* Facility protocol should address:
  . Ongoing inservice education of direct care staff.
  . Ongoing monitoring of technique of direct care staff.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 3 - PRESSURE ULCER TREATMENT

A) Type code: Intensity codes

1) Resident has been admitted with a stage I or II pressure ulcer.

2) Resident has been admitted with a stage III or IV pressure ulcer.

3) Resident has a stage I or II pressure ulcer that developed while in the facility.

4) Resident has a stage III or IV pressure ulcer that developed while in the facility.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 3 - PRESSURE ULCER TREATMENT

VERIFICATION OF LEVEL OF SERVICE

* Physician's order.
* Care plan or Treatment Plan.
* Observation of pressure ulcer.

NEED NOT MET

* Resident has a pressure ulcer and the facility is not addressing it with treatment or preventative program.
* Clinical record does not reflect current wound status.
* Specific treatment plan not being followed.
* Treatment not implemented by licensed personnel.
* Facility does not have or follow protocol for pressure ulcer management including notification of physician when pressure ulcer develops or when change in pressure ulcer occurs. Management program must include a resident assessment which addresses the following points:
  . Turning and positioning,
  . Nutritional support,
  . Nutritional assessment,
  . ROM,
  . Supportive devices, and
  . Infection control.

AGENCY NOTE

* Staging of pressure ulcers:
  . Stage I A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
  . Stage II A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
  . Stage III A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.
  . Stage IV A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.
* A stage I pressure ulcer can be suspected if a reddened area does not disappear 30 minutes after pressure is relieved.
* The skin of a stage II ulcer may appear bluish or dusky in color.
* Conditions that may be confused with pressure ulcers:
  . Stasis ulcers
  . Vasculitic ulcers
  . Amputation stump breakdown
  . Other open skin lesions such as basal cell carcinomas, burns, etc.
  . Skin rashes, including diaper rash
  . Fungal infections
* Score PROM, if it is being carried out according to the guidelines under PROM.
* Admission or risk assessment must indicate where pressure ulcer developed.

8-31-92

RULE

SECTION D: SERVICE NEEDS

CATEGORY 4 - PRESSURE ULCER PREVENTION

A) Type code: Intensity codes

1) Resident has been assessed, using an assessment instrument, to determine risk for developing pressure ulcers and has scored in the moderate risk category. A comprehensive preventative program as specified in the care plan is implemented and must address, but is not limited to, positioning schedules, range of motion program, nutritional support, and skin measures (i.e. whirlpool, etc.) as determined by facility policy.

2) Resident has been assessed, using an assessment instrument, to determine risk for developing pressure ulcers and has scored in the high risk category. A comprehensive preventative program as specified in the resident care plan is implemented and must address, but is not limited to, special mattresses or wheelchair cushions to reduce pressure, a positioning schedule, range of motion program, nutritional support and daily skin checks, and skin care measures (i.e. whirlpool, etc.) as dictated by a facility policy for high risk residents.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 4 - PRESSURE ULCER PREVENTION

VERIFICATION OF LEVEL OF SERVICE

* Assessment to indicate level of risk and reassessment per preventative plan.
* Preventative plan is in care plan.
* Observation of the resident to verify that the preventative plan is being carried out.

NEED NOT MET

* Individualized pressure ulcer preventative plan is not in care plan.
* Skin is not intact or signs of breakdown are present and the clinical record does not indicate observation and subsequent change of treatment plan.
* Preventative treatment plan not implemented.
* Facility is not following pressure ulcer prevention policy and procedures.
* Frequency of reassessments must be at least every 90 days, or more frequently if condition changes.

AGENCY NOTE

* Preventative Plan must address:
  . Frequency of observations of skin condition and documentation in the clinical record
  . Which type of staff should provide this care
* Assessment instruments must be standardized and must differentiate between moderate and high risk.
* Score PROM if it is being carried out according to the guidelines under PROM.
* If an individualized preventative plan is in question, refer to team physician.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 5 - WOUND CARE

A) Type code: Intensity codes

1) Dressings and/or skin treatments for noninfected areas.

2) Complex dressings (such as sterile dressings or post-op) and/or treatment to lesions that are infected.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 5 - WOUND CARE

VERIFICATION OF LEVEL OF SERVICE

* Physician's order.
* Treatment plan, care plan, Kardex or treatment sheet.
* Observation of wound and treatment being given.

NEED NOT MET

* Treatment not implemented using aseptic technique or as indicated in physician's order.
* Care not performed by licensed personnel.
* Wound present with no indication facility staff is aware of wound.
* Clinical record does not reflect current status of the wound.
* Physician is not notified of wound or change in wound status.
* Frequency of the documentation and observation of the wound status is not addressed in the individual treatment plan.
* No facility policy and procedure for wound care, including infection control.
* Infection control procedures not followed as per facility policy.

AGENCY NOTE

* Wound care (treatment of skin lesion, other than a pressure ulcer) may include wet packs, soaks, whirlpools for open lesions, or ointments when ordered by a physician and applied to lesions.
* "Friction burns" or abrasions resulting from repetitive friction are included in this category as are stasis ulcers, rashes, skin tears.
* Frequency of the documentation and observation of the wound status must be addressed in treatment plan until the wound is healed.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 6 - INJECTIONS

A) Type code: Frequency codes

1) Requires and receives injections less than daily but at least once a month, on a regular basis as per physician order.

2) Requires and receives one or more injections daily.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 6 - INJECTIONS

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Nurse's signature or initials must follow documentation of administration of injection.

NEED NOT MET

* Facility not following physician order.
* Injection site not documented or injection not documented as given.
* Injection site not free of signs of inflammation/irritation and the clinical record does not reflect this observation and there is no subsequent plan of action.
* Injection site not rotated according to facility protocol or facility has no protocol for rotation of injection sites.

AGENCY NOTE

* Yearly injections not included, i.e. flu shots, mantoux, etc.
* Credit is given for all other injections if the service received within the last six (6) months.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 7 - INTRAVENOUS THERAPY: I.V.'S AND CLYSIS

A) Type code: Frequency codes

1) Required and received I.V. or clysis for at least 48 hours (intermittent or continuous) during the past six (6) months.

2) Required and received I.V. or clysis seven or more days in past six (6) months.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 7 - I.V.s AND CLYSIS

VERIFICATION OF LEVEL OF SERVICE

* Physician's order.
* Nurse's signature or initials on medication or treatment record.

NEED NOT MET

* Insertion site not free of inflammation and the clinical record does not reflect this observation and a subsequent plan of care.
* I.V. tubing and dressing changes not done in accordance with facility's protocol.
* Facility does not have protocols for I.V.s or clysis.
* Facility does not follow it's own protocol on I.V.s or clysis.
* I.V. fluids or medications not documented as given per physician orders.
* Intake and output not recorded and monitored while on I.V. therapy.

AGENCY NOTE

* If I.V. is for hydration purposes, the clinical record should include documentation as to p.o. hydration attempts and resident's poor response.
* Credit is to be given for I.V.s or clysis if the service was received within the last six (6) months.
* Hickman Catheter, Groshong Catheter and heparin locks are included in this category.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 8 - LABORATORY SPECIMEN SERVICE

Type code: Frequency Code

1) One time in the last six (6) months.

2) Once a week.

3) Daily.

Resident required and facility staff collected one or more of the following: a specimen including blood specimen, urine specimen either by midstream "cleancatch" or by catheter, sputum specimen, stool specimen, swabs of throat, lesions, diabetic urine test, telephonic pacemaker check or electrocardiogram or oximeter or glucometer readings or checking and monitoring of shunts. Specimens collected by an outside lab are not included.

3-1-91

CATEGORY 8 - LABORATORY-SPECIMEN SERVICE

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Documentation that specimen was obtained by staff.
* Lab results conveyed to physician according to facility protocol.

NEED NOT MET

* Specimen not collected at specified times.
* Facility has no lab protocol.
* Staff does not adhere to facility's protocol for subsequent actions following receipt of laboratory report.
* Physician orders lab and facility does not complete.
* Site from which specimen is drawn not rotated according to facility protocol or facility has no protocol for rotation of sites.

AGENCY NOTE

* Protocol should address:
  . Level of staff who will collect each type of specimen
  . How specimens should be stored prior to testing
  . How licensed staff is informed of results of lab specimens collected by unlicensed staff
  . How licensed staff document action taken with specimen results
* Routine voided specimens are scored here.
* A physician referral should be made when a case manager questions whether lab work is necessary.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

Type code: Intensity Codes

1) Resident needs and receives medication four times a day or more during off-hours or by multiple routes, and requires routine monitoring to check for untoward reaction or side effects. Also included is a resident who needs and receives medication that requires special monitoring by licensed personnel with need for assessing and reporting to physician if necessary, changes in resident status, lab work, side effects, or apparent drug interactions. This can result in an adjustment of dosage or medication, or in continuing assessment of an unstable condition.

2) Resident is on a supervised program to increase or maintain an acquired level of independent self-administration of medication. The resident's cognitive, physical and visual ability to carry out this responsibility has been assessed by the interdisciplinary team. Nursing staff is responsible for drug storage and for recording self-administration in the resident's medication administration record.

OR

Resident is involved in a program to discontinue or reduce psychotropic medication to the lowest possible dose necessary to control symptoms.

AGENCY NOTE

* Psychotropic drugs refer to drugs which are used for anti-psychotic, anti-depressant, anti-manic, sedative-hypnotic, and/or anti-anxiety purposes, and which are intended to control mood, mental status, or behavior of the resident.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

BASE RATE SERVICES

* Routine med passes.
* Routine observation for medication side effects.
* Encouraging residents to take medications.
* PRN medication.
* Special monitoring done by licensed or unlicensd personnel with licensed supervision, including vital signs, lab work, and clinitests that result in few, if any, changes in dosage or medication or amount of assessment necessary.

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Nurse's signature or initials on the medication record following administration of medicine.
* Monthly documentation of pharmacist's review.
* Assessment/reassessment at least every 90 days with program noted on care plan. (Level 2 Only)
* Monthly documentation of resident response to self-medication program or psychotropic drug program by licensed nursing staff. (Level 2 only)

NEED NOT MET

* Facility does not have a protocol for self-medication or psychotropic drug management.
* Facility has not established medication protocol.
* Facility does not follow medication protocol as established.
* PRN medication given and reason for administration and response is not documented.
* Clinical record does not indicate resident's allergy, if applicable.
* Resident not given adequate hydration following ingestion of medications unless medications given with solids.
* Medication not documented as given and no documentation of reason medication was held.
* Medication not given within one (1) hour of scheduled time.
* Medication monitoring is not consistent.
* Medicated patches and topical medications are not rotated.
* On comprehensive assessment, the resident indicated a preference for self-medication (documented in clinical record) but the staff did not place the resident in a program for self medication or self-medication training and the clinical record does not reflect the interdisciplinary team's reason for denial of self-medication. (Level 2 only)
* Resident is self-medicating or on a training program for self-medication. Clinical record does not reflect monthly documentation of resident response to program; OR medication is not stored properly; OR medications are not documented as self-administered on medication administration record. (Level 2 only)
* Not following program plan as indicated on care plan. (Level 2 only)

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

NEED NOT MET

* Not following protocol for self-medication administration. (Level 2 only)
* Not following protocol for psychotropic management program. (Level 2 only)
* No monthly note by licensed nurse for self-medication or psychotropic drug management program. (Level 2 only)

AGENCY NOTES

* While there is no specific time limit on the duration of med monitoring, there must be evidence that the resident has not stabilized.
* Medications are scored the day of the survey unless a routine pattern has been established, i.e. every three days or every other day.
* Monitoring for injections is covered under the injections category.
* If the case manager wants verification from team physician as to whether special monitoring is necessary, mark physician referral.
* Example of "off hours or by multiple routes":
  . Oral medication given at 10 a.m., 3 p.m., 7 p.m., and 11 p.m..
  . Eye drops administered in left eye in the morning, in addition to oral medications.
  . Application of topical medications, i.e., nitro pads, nitro paste, estrogen patches, etc., or the use of an oral inhaler, i.e., Provental, Alupent, Aerobid, etc.
* If resident is now free of psychotropic drugs as a result of the drug reduction program, he/she may continue to be scored a level 2. The monthly progress note should address symptoms/alternate behavior interventions as well as resident response to the program.
* Credit should be given on Level 2 for self-medication when the program includes teaching the steps which lead to increased resident independence with regard to medications (i.e. the resident knowing the times of different medications, identifying the correct medication by sight and by purpose or name, knowing side effects to report to the doctor or nurse, physically taking the medication, etc.).
* Psychotropic medications shall not be administered for purposes of discipline or staff convenience and when not required to treat the resident's medical symptoms.
* To qualify for a psychotropic drug program (Level 2) at least the following elements must be in place:
  . Annual assessment with quarterly assessment reviews to re-examine need for dosage and type of medications to be given.
  . Care plan goals/approaches which include behavioral programming and dose reduction. Behavioral programming means modification of the resident's behavior and/or the resident's environment, including staff approaches to care, to the largest degree possible to accommodate the resident's behavioral disturbances.
  . Quarterly care plan review to determine if modifications are necessary.
  . Monthly review by pharmacist to look at resident response to the medications to detect problems (i.e. excessive PRN usage, demonstration of side effects, non-therapeutic blood levels, etc.) and report such to DON and/or physician.
  . Ongoing observation and at least monthly documentation of resident reaction to medication(s) including possible side effects or other problems by licensed nursing staff.

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

AGENCY NOTES

* Not all psychotropic medications are appropriate for dose reduction or behavioral programming and therefore would not qualify for scoring under Level 2.
* A plan for increased independence in self-medication must be developed on all medications a resident receives; however, a resident does not have to demonstrate successful self-medicating progress for all medications prescribed in order to receive credit for Level 2.
* Credit for Level 2 self-medication is also given for any resident who has successfully learned to self-medicate (with nurse monitoring) or who has successfully learned steps toward increased independence in the area of medication and is maintained at that level. Resident continues to be assessed for increased independence and a monthly documentation indicates the resident response. Eye drops, antacids, etc. can be included under self-medication if prescribed by a physician and not given on PRN basis.
* Resident may receive credit on both level 2 medication and for psychosocial programming.
* The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of pharmacy services in the facility.
* The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist who must report any irregularities to the attending physician and the director of nursing and these reports must be acted upon.
* Facility protocol for psychotropic drug programs should include, but is not limited to, graduated dose reduction and behavioral programming, unless clinically contraindicated, in an effort to discontinue these drugs.

* COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS

TABLE A. ANTIPSYCHOTIC (NEUROLEPTIC) DRUGS

Generic Name*	Brand Name
Chloropromazine	Thorazine
Promazine	Sparine
Triflupromazine	Vesprin
Thioridizine	Mellaril
Mesoridazine	Serentil
Acetophenazine	Tindal
Perphenazine	Trilafon
Loxapine	Loxitane
Molindone	Moban
Trifluoperazine	Stelazine
Thiothixene	Navane
Fluphenazine	Prolixin,Permitil Deconate
Fluphenazine	Prolixin Deconate
Haloperidol	Haldol Deconate
Haloperidol	Haldol Deconate

Droperidol	Inapsine
Chlorprothixene	Taractan
Pimozide	Orap

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

AGENCY NOTES

TABLE B. ANTIDEPRESSANT DRUGS

Generic Name	Brand Name
CYCLIC ANTIDEPRSSANT	
Imipramine	Tofranil
Desipramine	Norpramin
Doxepin	Adapin Sinequan
Amitriptyline	Elavil Triavil
Nortriptyline	Aventyl Pamelor
Maprotiline	Ludiomil
Amoxapine*	Asendin
Fluoxetine	Prozac
TRIAZOLOPYRIDINE ANTIDEPRESSANT	
Trazodone	Desyrel
MAO INHIBITORS-	
Phenelzine	Nardil
Tranylcypromine	Parnate
PHENYLAMINOKETONE	
Bupropion	Wellbutrin

* Also a neuroleptic drug with all the neuroleptic side effects.
+ Special diet required; many drug interactions.

AGENCY NOTES (continued)

TABLE C. ANTIANXIETY AND HYPNOTIC DRUGS

Generic Name	Brand Name
BENZODIAZEPINES	
Oxazepam	Serax
Lorazepan	Ativan
Alprazolam	Xanax
Chlorodiazepoxide	Librium
Diazepam	Valium
Chlorazepate	Tranxene
Flurazepam	Dalmane
BARBITURATES/ANTIHISTAMINES	
Hydroxyzine	Vistaril
OTHER	
Buspirone	Buspar

3-1-91

CATEGORY 9 - MEDICATIONS/MEDICATION MONITORING

AGENCY NOTES

TABLE D. ANTIMANIC

Generic Name	Brand Name
Lithium Carbonate	Eskalith
	Lithonate
	Lithane
	Lithotabs
	Lithobid (slow release)
	Eiskalith CR (controlled release)
Lithium Citrate	Cibalith-S

Serum lithium determinations recommended once or twice weekly during treatment of acute manic episode until serum concertrations and patient's clinical condition have stabilized; recommended at least every 2 to 3 months during remission when patient is stabilized.

TABLE E. Antipsychotics should not be used if one or more of the following is/are the only indication(s):

- Wandering
- Simple pacing
- Crying out, yelling or screaming if such behaviors do not cause an impairment in functional capacity or if they are not quantitatively documented by the facility.
- Poor self care
- Restlessness
- Impaired memory
- Anxiety
- Depression
- Insomnia
- Unsociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness
- PRN use greater than 5 doses in a seven day period without a review of the resident's condition by a physician.
- Unspecified Agitation

RULE

SECTION D: SERVICE NEEDS

CATEGORY 10 - OCCUPATIONAL THERAPY AND RELATED REHABILITATION SERVICES

A) Type code: Intensity Code

1) The occupational rehabilitation program shall be ordered by a physician. It shall be planned and designed specifically for the resident by an occupational therapist registered/licensed (OTR/L). The occupational rehabilitation services program shall be administered by a rehabilitation aide under the supervision of the OTR/L. There shall be a monthly review of progress documented by the OTR/L, or if written by the rehabilitation aide, co-signed by the OTR/L.

2) The occupational therapy program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the OTR/L. The direct occupational therapy services shall be administered by a certified occupational therapy assistant/licensed (COTA/L) under the supervision of the OTR/L. There shall be a review of the progress documented either by the OTR/L or COTA/L monthly. The OTR/L must cosign the COTA/L's documentation monthly.

3) The occupational therapy shall be ordered by a physician. It shall be planned and designed specifically for the resident by an OTR/L. This plan must include measurable goals. The program shall be carried out on a regularly scheduled basis by an individual with qualifications of an OTR/L. There must be a review of progress towards goals documented by the OTR/L every month.

NOTE: There must be a reasonable likelihood that the occupational therapy and/or the occupational rehabilitation services will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan review by the interdisciplinary team.

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 10 - OCCUPATIONAL THERAPY AND RELATED REHABILITATION SERVICES

B) Agency Note: Prior to a resident being given credit in occupational rehabilitation services, the following must be met (Level 1 only):

1) A corresponding ADL restorative program must be developed to increase the resident's functional ability and it must be carried out by the nursing department. The resident's response to the intervention must be recorded in the clinical record.

2) The occupational rehabilitation aide must be a certified nurse aide, or have a related degree, or two years of college in a related field, or an approved 36 hour activity course and has received specified training as outlined and approved by the Department of Public Aid.

3) For residents with a diagnosis of mental illness, if occupational rehabilitation is scored, a psychosocial and/or a corresponding ADL program must have been developed and scored.

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Assessment and program planned by the OTR/L.
* Observation of rehabilitation aide conducting therapy sessions (Level 1 only).
* Monthly review of progress documented by the OTR/L or if written by the rehabilitation aide, reviewed and cosigned by the OTR/L.
* Assessment every 90 days.
* Corresponding ADL or psychosocial (for MI diagnosis) program has been developed and implemented (Level 1 only).
* Observation of COTA/L conducting therapy sessions (Level 2 only). Observation of OTR/L conducting therapy sessions (Level 3 only).

NEED NOT MET

* Plan is not implemented as specified by the therapist.
* Goals are not designed to increase resident's functional capabilities.
* Resident is not meeting goal(s) and clinical record does not indicate staff is addressing lack of progress.
* Resident attended less than 85% of the scheduled sessions in the last three months or since the service began, if less than three months, and clinical record does not indicate resident absenteeism was due to illness or absence from the facility (Level 1 only).
* Rehab aide is not a CNA or equivalent. Rehab aide has not received specified training, or has not been enrolled in a rehabilitation course as outlined and approved by IDPA within 90 days of the beginning date of employment in the rehab aide position (Level 1 only).

8-2-93

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 10 - OCCUPATIONAL THERAPY AND RELATED REHABILITATION SERVICES

AGENCY NOTE

*Reimbursement for this item includes assessment done by OTR/L.
*The nurse case manager must verify the accuracy of the rehabilitation records by checking the clinical records of at least 25% of the residents in therapy, verifying services were delivered (Level 1 only).
*If progress was not made within two months and goals or interventions were not changed, do not score.
*Progress should be noted by standard acceptable OTR/L objective measures.
*Staffing ratios for rehabilitation 1:30 (per total enrollment)-98 minutes (Level 1 only). Staffing ratios for therapies for OT Level 2 and Level 3 - 1:1.5 (per 98 minutes).
*Rehabilitation groups are limited to four residents with similar goals and levels of functioning (Level 1 only).
*Use of Paraffin Heat Treatments, Fluido Therapy, whirlpool may be scored when ordered by a physician and carried out (Level 2 or 3 only).
*Refer to Appendix B for Occupational Therapy and Related Rehabilitative Services Measurement of Progress.

8-2-93

RULE

SECTION D: SERVICE NEEDS

CATEGORY 11 - PHYSICAL THERAPY AND RELATED REHABILITATION SERVICES

A) Type code: Intensity Code

1) The physical rehabilitation program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the physical therapist (PT). The physical rehabilitation services shall be administered by a rehabilitation aide under the supervision of the PT. There shall be a monthly review of the progress documented by the PT or if written by the rehabilitation aide, co-signed by the PT.

2) The physical therapy program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the PT. The direct physical therapy services shall be administered by a physical therapist assistant (PTA) under the supervision of the PT. There shall be a review of the progress documented either by the PT, or the PTA monthly. The PT must cosign the PTA's documentation monthly.

3) Physical therapy shall be planned and designed specifically for the resident by a PT. This plan must include measurable goals. The program shall be carried out on a regularly scheduled basis by an individual with qualifications of a PT. There must be a review of progress toward goals documented by the PT monthly.

NOTE: There must be a reasonable likelihood that the physical therapy and/or the physical rehabilitation services will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan review by the interdisciplinary team.

8-2-93

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 11 - PHYSICAL THERAPY AND RELATED REHABILITATION SERVICES

B) Agency Note: Prior to a resident being given credit in physical rehabilitation services, the following must be met (Level 1 only):

1) A corresponding ADL restorative program must be developed to increase the resident's functional ability and it must be carried out by the nursing department. The resident's response to the intervention must be recorded in the clinical record.

2) The physical rehabilitation aide must be a certified nurse aide, or have completed at least one year of nurses training and have received specified training as outlined and approved by the Illinois Department of Public Aid.

3) For residents with a diagnosis of mental illness, if physical rehabilitation is scored, a psychosocial and/or a corresponding ADL program must have been developed and scored.

VERIFICATION OF LEVEL OF SERVICE

* Physician order (Level 1 and 2 only).
* Assessment and program planned by the therapist.
* Observation of rehabilitation aide conducting therapy sessions (Level 1 only).
* Monthly review progress documented by the PT or, if written by the rehabilitation aide, reviewed and cosigned by the PT.
* Assessment every 90 days.
* Corresponding ADL program or psychosocial (for MI diagnosis) program has been developed and implemented (Level 1 only).
* Observation of PTA conducting therapy sessions (Level 2 only). Observation of PT conducting therapy sessions (Level 3 only).

NEED NOT MET

* Plan is not implemented as specified by the therapist.
* Goals are not designed to increase resident's functional capabilities.
* Resident is not meeting goal(s) and clinical record does not indicate staff is addressing lack of progress.
* Resident attended less than 85% of the scheduled sessions in the last three months or since the service began, if less than three months, and clinical record does not indicate resident absenteeism was due to illness or absence from the facility (Level 1 only).
* Rehab aide is not a CNA or equivalent. Rehab aide has not received specified training, or has not been enrolled in a rehabilitation course as outlined and approved by IDPA within 90 days of the beginning date of employment in the rehab aide position (Level 1 only).

8-2-93

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 11 - PHYSICAL THERAPY AND RELATED REHABILITATION SERVICES

AGENCY NOTE

* Reimbursement for this item includes assessment done by registered PT.
* The nurse case manager must verify the accuracy of the rehabilitation records by checking the clinical records of at least 25% of the residents in therapy, verifying services were delivered (Level 1 only).
* If progress was not made within two months and goals or interventions were not changed, do not score.
* Progress should be noted by standard acceptable PT objective measures.
* Staffing ratios for rehabilitation 1:30 (per total enrollment)-98 minutes (Level 1 only). Staffing ratios for therapy for PT Level 2 and Level 3 - 1:1.5 (per 98 minutes).
* Rehabilitation groups are limited to four residents with similar goals and levels of functioning (Level 1 only).
* Refer to Appendix B for Physical Therapy and Rehabilitative Measurement of Progress.

8-2-93

RULE

SECTION D: SERVICE NEEDS

CATEGORY 12 - PASSIVE RANGE OF MOTION (PROM)

A) Type code: Frequency code

1) Resident requires and receives PROM exercises to at least one extremity at least two times per day.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 12 - PASSIVE RANGE OF MOTION

VERIFICATION OF LEVEL OF SERVICE

* Care plan or Treatment Sheet.
* Observation of resident to determine overall ability to use extremities.
* Observation of staff actually performing PROM and indication that plan is carried out regularly and routinely.
* Residents with existing contractures must have physician's orders although PROM for most residents does not require a physician's order.
* Monthly documentation of resident's response to intervention in clinical record. Documentation may be done by the staff providing the service.

NEED NOT MET

* Facility has no PROM protocol.
* The plan as indicated on the care plan or Treatment Sheet is not being implemented and documented.
* Documentation of resident's response to intervention is not documented in clinical record at least monthly.
* Resident has contractures or is at risk of developing contractures that are not being addressed.

AGENCY NOTE

* PROM that is also part of a pressure ulcer treatment and/or prevention program will be scored in both places.
* The required documentation should reflect the resident's response to treatment, i.e., resident is able to raise arm shoulder level; the resident remains contracture free.
* PROM protocol must address:
  . On-going inservice education of direct care staff.
  . On-going monitoring of PROM technique of direct care staff.
* CNA may document response to PROM if cosigned by licensed staff.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 13 - OSTOMY CARE

A) Type code: Intensity codes

Includes gastrostomy, ileostomy, jejunostomy and colostomy.

1) Uncomplicated care of ostomy (Gastrostomy included). Includes routine care and maintenance of the ostomy, i.e., cleansing and appliance change.

2) Complex ostomy includes post/op operative, ostomies, care of Percutaneous Endoscopic Gastrostomy (PEG) tubes, or an ostomy that, given the patient's overall condition, requires licensed care. All ostomies that have become excoriated or require a prescription medication application are included.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 13 - OSTOMY CARE

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Observation of ostomy care and a review of the treatment plan.

NEED NOT MET

* Facility does not have protocol for ostomy care.
* Staff does not adhere to physician's orders or facility's protocol and written procedures for ostomy care and maintenance.
* Excoriation observed with no indication in the clinical record and the plan of care is not altered.
* Care not performed by licensed personnel, other than routine change of colostomy bag.

AGENCY NOTE

* Colostomy bag can be changed by a CNA trained in ostomy care when allowed by facility protocol. (Level 1 only)
* Facility protocol should address:
    . Ongoing inservice education of direct care staff
    . Ongoing monitoring of technique of direct care staff

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 14 - RESPIRATORY THERAPY

A) Type code: Intensity codes

1) Uncomplicated provision of these therapies. Resident is capable of administering his/her own respiratory therapy (oxygen and humidity) with minimum assistance from licensed personnel and routine monitoring by staff.

2) Complex due to the nature of the resident's condition, type procedure or multiplicity of procedures required. Positive pressure breathing therapy, aerosol therapy, etc. and complicated problems with oxygen-humidity is required by resident. Resident is totally dependent upon administration by licensed staff.

B) Respiratory therapy includes oxygen, positive pressure breathing therapy, humidity therapy, aerosol therapy, postural drainage, percussion or vibration. Room humidifiers are not included.

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 14 - RESPIRATORY THERAPY

VERIFICATION OF LEVEL OF SERVICE

* Physician order must include:
  . Delivery system, oxygen flow rate and/or frequency of IPPB treatments, postural drainage, percussion and/or vibration and use of suctioning in conjunction with these therapies, if indicated.
* Observation of therapy.
* Documentation of procedure and results by licensed staff. (level 2)
* Monthly progress note by licensed staff. (level 2)

NEED NOT MET

. Facility does not have protocol for respiratory therapy.
. Respiratory therapy protocol is not being followed.
. Treatment is ordered, but not carried out as specified.
. Equipment soiled and/or non-functional or not available.
. Respiratory therapy not performed by licensed staff. (level 2)

AGENCY NOTE

* Level 1 resident is capable of administering own therapy.
* Level 2 resident is totally dependent upon licensed staff for administration.
* Protocol should address:
  . Which staff provide which type service
  . Infection control procedures
  . Staff training required to carry out these services
  . Frequency for assessment of respiratory status should be recorded in the clinical record
  . Conditions or diagnoses which are indications and contraindications for the use of postural drainage, percussion and vibration.
* Intensity code scoring is to reflect current level of needs.
* Licensed personnel who carry out postural drainage, percussion and vibration shall have ongoing in service training by a respiratory therapist.
* The use of postural drainage, percussion and vibration is restriceted to those residents who produce 30 cc or more of secretions daily.
* A physician's order for postural drainage, percussion and vibration can be for a maximum of 30 days. The physician is then required to reevaluate the resident before a new order is written.
* Suctioning which is done in conjunction with postural drainage, percussion and vibration is not to be scored under the suctioning category.
* The care plan for residents who are in a program of postural drainage, percussion and vibration must include a pulmonary hygiene program which includes, but is not limited to the following:
  . hydration
  . nutrition
  . rest
  . absence of environmental pollutants

8-31-92

RULE

SECTION D: SERVICE NEEDS

CATEGORY 15 - SUCTIONING

A) Type code: Frequency codes

1) Daily.

2) Twice or more daily.

8-31-92

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 15 - SUCTIONING

VERIFICATION OF LEVEL OF SERVICE

* Physician order.
* Observe treatment.

NEED NOT MET

* Facility does not have protocol for suctioning.
* Staff does not follow facility protocol.
* Care not performed by licensed personnel.
* Equipment soiled and/or non-functional and/or not readily available.

AGENCY NOTE

* Facility's protocol should address guidelines for maintaining sterility and/or cleanliness of catheters.
* Suctioning done during tracheostomy care is included as part of tracheostomy care. Additional suctioning must be done at other times to be scored here.
* Review last 30 days documentation to score this section.
* Suctioning done in conjunction with postural drainage, percussion and vibration is not to be scored under the suctioning category.

8-31-92

RULE

SECTION D: SERVICE NEEDS

CATEGORY 16 - TRACHEOSTOMY CARE

A) Type code: Intensity codes.

1) Requires routine cleansing of tracheostomy site and non-sterile dressing change.** Tracheostomy care managed by staff.

2) Requires and receives complex care to tracheostomy site more than one time daily which includes the changing of sterile or complex dressings, suctioning or changing of the tracheostomy tube, and/or monitoring of unstable respiratory status.*

B) Includes care of tracheostomy site.

* and ** See Suctioning, Category 15

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 16 - TRACHEOSTOMY CARE

VERIFICATION OF LEVEL OF SERVICE

* Physician order.

NEED NOT MET

* Facility has no tracheostomy care protocol.
* Staff does not follow physician's order or facility's protocol for tracheostomy care.
* Care not performed by licensed personnel.
* An extra tracheostomy tube, the same size as the one in place, is not available at the bedside.
* Tracheosotmy care is not documented.
* Equipment soiled and/or non-functional and/or not readily available.

AGENCY NOTE

* Protocol should address:
  . Training licensed staff must have prior to providing this service:
  . Guidelines for infection control;
  . Frequency for observations of ostomy site and respiratory status should be recorded in the clinical record; and
  . Guidelines for maintaining sterility and/or cleanliness of catheters.
* Only suctioning done during tracheostomy care is scored here.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 17 - DISCHARGE PLANNING

A) Type Code: Intensity code

1) A specific discharge plan has been developed by an interdisciplinary team and reflected in the resident care plan. Includes only residents with discharge anticipated within the next three (3) months to a less restrictive environment. This plan shall include family and other state agency programs where appropriate (i.e., Department on Aging and Department of Rehabilitation Services). Discharge of the resident need not be accomplished provided the plan has been implemented and the services were within the past six (6) months.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 17 - DISCHARGE PLANNING

VERIFICATION OF LEVEL OF SERVICE

* Care plan.
* Indication plan is being followed.

NEED NOT MET

* Plan not being followed.

AGENCY NOTE

* Discharge must be to less restrictive environment, i.e. shelter care, room and board or independent living arrangements and anticipated within three (3) months.
* Credit may be given for discharge planning if the service was received within the last six (6) months.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 18 - HEALTH AND FITNESS PROGRAM

A) Type Code: Intensity Codes

1) A health and fitness program has been specifically developed for the resident by a licensed nurse. The fitness program is written on the resident's fitness card. Following the resident's attendance, participation in the specific routine(s) must be recorded on the resident's fitness card. The program is carried out at least three times per week. The resident's response to the program must be documented in the clinical record one time per month.

Fitness routines should vary based on resident's physical condition, fitness preferences and plan of care. Programs may be self-monitored. Programs may consist of, but are not limited to walking/fitness trails, flexibility exercises, endurance maintenance, wheelchair pushups, swimming, biking, basketball, baseball, and/or volleyball.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 18 - HEALTH AND FITNESS PROGRAM

VERIFICATION OF LEVEL OF SERVICE

* Fitness card.
* Observation of program to see that the plan is being carried out as written on the fitness card.

NEED NOT MET

* Health and Fitness program developed by unlicensed staff.
* Plan not carried out.
* Equipment required to carry out fitness program, as required on the fitness card, is soiled and/or non-functioning, or is not available.
* The resident's response to intervention is not documented in the clinical record once a month.
* Groups are larger than six (6) unless activity is a team sport.

AGENCY NOTE

* The program may also be developed by an Occupational Therapist, Physical Therapist, Certified Therapeutic Recreation Specialist, a Physician or Physiatrist.
* Do not score when resident does not carry out fitness program an average of three (3) times per week.
* Activity programs including exercises must be separate and apart from health and fitness.
* Fitness programs must address all extremities, unless contraindicated.
* Unlicensed staff may document response to Health and Fitness Program if cosigned by licensed staff.

3-1-91

RULE

SECTION D: SERVICE NEEDS

CATEGORY 19 - RESTRAINT MANAGEMENT AND REDUCTION

A) Type Code: Intensity Codes

1) The resident has been assessed by licensed staff and, for clearly documented reasons which are not life threatening, has been determined to be in need of a physical restraint. After explanation of the need for a physical restraint, the resident, family (if appropriate), guardian or legal representative has consented to the use of the physical restraint.

The staff has attempted less restrictive measures and documented the results. Consultation has taken place with appropriate health professionals, such as physician, occupational therapist, physical therapist, or rehab certified registered nurse, in the use of less restrictive supportive devices or methods. Where appropriate, the less restrictive measures have been successfully maintained, without the use of physical restraints.

Where less restrictive measures have not been successful and physical restraints have been applied, the care plan documents the duration, type and circumstances under which the restraint can be used.

The restraints are properly applied and the resident is released from the restraint, exercised or ambulated, and repositioned at least every two hours for at least 10 minutes. The care plan indicates that at least every quarter, the interdisciplinary team reviewed the continuing need for restraints and that reduction in duration or less restrictive measures have been discussed. As the interdisciplinary team determines, an individualized restraint reduction program is developed and implemented.

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 19 - RESTRAINT MANAGEMENT AND REDUCTION

BASE RATE SERVICES

The resident does not have an assessed need to be physically restrained because of a continuing health, functional or psychosocial condition. A physical restraint may be used temporarily to provide necessary life saving treatment, if there are medical symptoms which are life threatening. A physical restraint may be used for brief periods to allow medical treatment to proceed if there is documented evidence of the resident's or legal representative's approval of the temporary physical restraint. If a temporary physical restraint is needed because of medical symptoms which are life threatening, documented attempts at less restrictive measures prior to application of the physical restraint are not required.

VERIFICATION OF LEVEL OF SERVICE

* Physician Order
* Assessment/reassessment at least every 90 days with program noted on Care Plan
* Observation of resident
* Monthly documentation of resident response co-signed by licensed staff

NEED NOT MET

* A resident is physically restrained and there is no documentation of consultation with appropriate health professionals, such as physician, occupational therapist, physical therapist, or rehabilitation certified registered nurse, in the use of less restrictive supportive devices or methods.
* Protocol not developed for restraint reduction and restraint management.
* The resident is physically restrained and there is no documentation of consultation and agreement by the resident, family, if appropriate, guardian or legal representative to the use of restraints.
* A resident is physically restrained and there is no assessment/documentation to justify restraint.
* The restrained resident is not released at least every two hours for at least ten minutes, repositioned and exercised and/or ambulated and/or toileted and/or checked for skin redness and/or given nutrition/hydration as required.
* Restraints are not applied according to physician order.
* Resident restrained without physician order.
* Restraint reduction program not implemented as specified in the care plan.
* Resident not meeting goals of the restraint reduction program and the clinical record does not indicate that the staff is addressing the lack of progress.
* Resident response to restraint or reduction program is not documented in the clinical record at least monthly, reassessment not completed every 90 days, or not co-signed by licensed staff.
* Restraint device is not clean; or found to be in ill repair; or improperly sized.
* Restraint device is not properly applied.
* Facility not following protocol for care application, maintenance, and reduction of each type of restraint used.
* A resident placed in restraint is not checked at least every 30 minutes by staff trained in the use of restraints.

3-1-91

INTERPRETATIVE GUIDELINES
ICF/SNF FACILITIES

CATEGORY 19 - RESTRAINT MANAGEMENT AND REDUCTION
AGENCY NOTE

* Residents who are free of restraints because of alternative programming are still eligible for scoring on level 1, providing the quarterly reassessment continues to indicate that the specific staff intervention is needed to maintain the resident free of restraints, the need and intervention is specified in the care plan, and monthly documentation of resident response to intervention continues.
* This item can not be scored and a need not met can be given if:
  . There is no physician order for the use of a restraint and the resident is restrained, OR
  . The restrained resident is not in a restraint program and the restraint is improperly applied.
  . The restrained resident is not in a restraint program and is not released at least every two hours for at least ten minutes, repositioned and exercised and/or ambulated and/or toileted and/or checked for skin redness and/or given nutrition/hydration as required.
* The facility must not issue orders for restraint on a standing or as needed basis.
* Assessment includes, but is not limited to:
  . Reason for use of the restraint.
  . Documentation of attempts made in ways of using less restrictive measures and why they were unsuccessful.
  . Address communication needs and functional abilities.
* Care Plan includes, but is not limited to:
  . Alternative interventions used in place of restraints
  . If restraint must be used, include:
    - Reason for use of the restraint.
    - Type(s) of restraint used.
    - Duration and time of day restraint is to be used.
    - Location of resident when restrained (i.e. own room in bed, chair in hall).
    - Under what circumstances are restraints being used (i.e. when left alone, after family leaves, when not involved in structured activity, when eating).
  . Address communication needs and functional abilities.
* Monthly response note should address functional and mental status of resident before, during and after use of restraints. Documentation of attempts made in ways of using less restrictive measures and why they were unsuccessful.
* Physician order should include:
  . Reason for restraint.
  . Length of time restraint is to be used.
  . Type of restraint to be used.
* A resident should be released from restraints as soon as there is no longer a need.
* A resident should not be physically or chemically restrained for the purpose of discipline or staff convenience.
* Restraint usage should be periodically re-evaluated and efforts to eliminate use of restraint should be attempted and documented in the clinical record. When the restraint usage is re-evaluated, the functional status of the resident should be reviewed to ensure that no loss of function has occurred as a result of restraint usage. If a loss of function can be attributed to the use of the restraint, the facility should take prompt action to review restraint use with the physician to discuss alternative treatment.

8-31-92

RULE

SECTION E: SOCIAL SERVICES

1. Type Code: Intensity Codes

    1) Resident and/or family and/or guardian counseled on residents rights at admission, and reviewed individually with residents and/or family and/or guardian at least annually. Staff orients resident and/or family and/or guardian to facility programs, Medicare/Medicaid programs (including prevention of spousal impoverishment), advance directives, available medical services, community support services, and the resident's personal allowances, and gives assistance to resident in applying for any needed services. Facility ascertains and arranges to secure or provide resident's choice of pastoral care. Resident and/or family and/or guardian are encouraged to participate in care plan conferences. Facility acquaints resident with resident council purpose/functions and encourages participation.

    2) To qualify for Level 2, all Level 1 requirements must be in place as well as the following: Resident has participated in a monthly standard social service interview soliciting resident opinions and preferences about defined aspects of the quality of life in the facility. If resident is unable to participate in this interview, a family or guardian interview, in person or by phone, may be done on a monthly basis.

AGENCY NOTE

* If a resident or family or guardian is unable to attend a care conference, the facility provides an opportunity and documents efforts to discuss problems/issues with resident or family or guardian at least quarterly either by individual or family or guardian conferences or by letter or by phone.

8-31-92

SECTION E: SOCIAL SERVICES

VERIFICATION OF LEVEL OF SERVICES

* Initial (annual) assessment present and updated as needed every 90 days or sooner if the resident has experienced a significant change in status.
* Initial history present and updated.
* Social Service needs identified on the assessment are addressed on care plan.
* Quarterly notes (co-signed by a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, if necessary). (Level 1)
* Monthly notes (co-signed by a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, if necessary). (Level 2)
* Signed documentation that resident has been informed of his/her rights, initially and annually thereafter.
* Signed documentation in records denoting that staff has counseled resident and/or family and/or guardian on Medicare/Medicaid programs (including prevention of spousal impoverishment), advance directives, medical services, community support services, personal allowances, initially and annually thereafter and assisted with applications as needed.
* Documentation of contacts made or attempted or services provided with resident's choice of pastoral care.
* Copies of letters sent to family/guardian encouraging them to attend the care plan conference and/or family/guardian signature on care plan and/or documentation in the clinical record that the resident was encouraged to attend care plan conference.
* Documentation that staff has counseled resident and/or family and/or guardian on resident council functions, purpose, etc.
* Documented results of follow-up to standard monthly interview. (Level 2)

NEED NOT MET

* Initial (annual) assessment not present or current or accurate.
* Social history not present or current.
* Identified needs not addressed on care plan.
* No documentation that resident is informed of rights initially or annually.
* No documentation that resident has been informed of Medicare/Medicaid or other community programs available initially and annually thereafter . No assistance given in applying for such services.
* No documentation of attempts to secure choice of pastoral services.
* No documentation of resident or family invitation to care plan conferences.
* No documentation of attempts, at least annually, to involve resident in resident council.
* No documentation of monthly resident interviews or follow-up to issues uncovered during the interview. (Level 2 Only)

6-1-93

SECTION E: SOCIAL SERVICES

AGENCY NOTES

* The standard Social Service interview should include questions concerning:
  . Dining
  . Schedule Preferences
  . Activity Preferences, including Recreation and Social Contacts, Clubs and Hobbies
  . Outside Contacts
  . Money Matters
  . Care Delivery
  . Care Planning
  . Security and Personal Property
  . Privacy
  . Resident Compliments and Complaints
  . Other Social Service Concerns
  . Resident Council
  . Family Involvement
* Initial history should include, but is not limited to, occupational, educational and family history.
* Social service designees (not a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, but performing social work duties in facility) must have on-going consultation of licensed social worker, with notes co-signed by the licensed social worker or a person with a bachelor's degree in social work or a bachelor's degree in a human services field including; but not limited to, sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. Facilities shall also meet the social service requirements as set forth in 77 Ill. Adm. Code 300.

SECTION F: ACTIVITIES

AGENCY

ITEM	CODING SPECIFICATIONS	NOTE
1.	Adequate Activities	Y = The resident has a current activity plan of care and is receiving an appropriate activity program.

- Needs Not Met

A. There is no program assessment of activity needs.

N = Activity needs of the resident are not being met by the facility.

B. Assessment does not reflect current interests and needs.

MAKE BRIEF CONCISE STATEMENT REGARDING UNMET NEEDS AND/OR RECOMMENDATIONS

C. Initial activity plan has not been established.
D. Minimum standards for activities have not been met.
E. Activity plan has not been individualized.
F. Activities have not been incor- porated into the interdisciplinary care plan.
G. Progress notes are not current (quarterly).

3-1-91

SECTION G: Determinations

INSTRUCTIONS: Circle Codes Y or N, or in #3, recommended level as appropriate under each item.

ITEM	CODING SPECIFICATIONS	AGENCY NOTE
1.	Facility Referral	Y = Resident has unmet needs in functional or service areas or N's circled under A: Physician Service areas or E: Social Services and the facility must develop a plan for correction. N = Resident has no unmet needs and/or resident is not being referred to team physician for review.
2.	Present Level of Care (Level currently certified)	CODE LEVEL CERTIFIED BY PHYSICIAN ON FORM DPA 2448 1 = SNF 6 = Psychiatric Sheltered care and 2 = ICF Hospital Room and Board
3.	Recommended Level of Care	1 = SNF 5 = Acute general hospital 2 = ICF 6 = Psychiatric hospital 3 = Sheltered 7 = ICF/DD 4 = Room and Board 8 = ICF/MR (SNF/PED)
4.	Recommendation	1 = Resident is receiving appropriate level of care and may remain in this facility. 2 =Resident is not receiving appropriate level of care and must be transferred to another facility providing the level of care as indicated elsewhere on this form. IF CODE 2 IS USED, SECTION E, ITEM 5 MUST BE CIRCLED"Y". Each resident with a recommendation of 2 or 4, will be referred to the team physician. DPA 2704 must be completed for resident marked 2 or 4. 3 =Resident is not currently receiving appropriate level of care. Resident may remain in the facility. However, certified DPA 2448 is needed reflecting changed level of care. 4 =Resident has potential for discharge. Facility should proceed with discharge. IF CODE 4 IS USED, SECTION E, ITEM 5 MUST BE CIRCLED.

SECTION G: Determinations

INSTRUCTIONS: Circle Codes Y or N, or in #3, recommended level as appropriate under each item.

		AGENCY
ITEM	CODING SPECIFICATIONS	NOTE
5.	Physician Referral	Y =Resident is being referred to the team physician for review. Each resident marked "Y" referral will be referred to the team physician. DPA 2704 must be completed for those residents marked “Y”. N =Resident is not being referred to the team physician for review.
6.	Negotiations	Y =The facility did indicate areas of dispute and did provide supportive documentation. N =The facility did not indicate areas of dispute and/or did not provide supportive documentation.
7.	Arbitration	Y =The facility is contesting some level of scoring on this form. Forms 2700A/2700B must reflect each contested item with explanation. N =The facility is not contesting any level of scoring on this form.

SECTION H: SIGNATURES

ITEM	CODING SPECIFICATIONS	AGENCY NOTE
1. HFSN ID NUMBER	NUMBER MUST BE WRITTEN IN HE FOLLOWING SEQUENCE. REGION NUMBER (TWO DIGITS) HFSN ID NUMBER (THREE DIGITS) e.g. 07140.	
2. ASSESSMENT DATE	THE ASSESSMENT DATE MUST BE ENTERED AS A SIX (6) DIGIT NUMBER ON EACH FORM COMPLETED e.g. 09/08/86.	
3. HFSN SIGNATURE	FULL NAME OF NURSE COMPLETING THE FORM.	
4. EXIT DATE	DATE THE EXIT CONFERENCE CONCLUDED. THE EXIT DATE MUST BE ENTERED AS A SIX (6) DIGIT NUMBER ON EACH FORM e.g. 09/09/86. THIS DATE MUST CORRESPOND TO THE LAST DATE IN SECTION A-5, DATE OF REVIEW, DPA 2702.	
5. SOCIAL WORKER ID NUMBER	NUMBER MUST BE WRITTEN IN THE FOLLOWING SEQUENCE WHEN THERE IS A SOCIAL WORKER SIGNATURE: REGION NUMBER (TWO DIGITS) SOCIAL WORKER ID NUMBER (THREE DIGITS) e.g. 07098	
6. ASSESSMENT DATE	THE ASSESSMENT DATE MUST BE ENTERED AS A SIX (6) DIGIT NUMBER WHEN THERE IS A SOCIAL WORKER SIGNATURE e.g. 09/08/86.	
7. SOCIAL WORKER SIGNATURE	FULL NAME OF SOCIAL WORKER (MAC II) COMPLETING SECTION E.	

3-1-91

APPENDIX A: DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) ADAPTIVE EQUIPMENT

ADL adaptive equipment refers to any device applied to the hand or arm that allows for independence in eating, grooming, writing, bathing, dressing.

AGENCY NOTE

Clarification for Department staff and providers regarding interpretation of the administrative rule or interpretative guidelines.

AMBULATE

Process of moving from one place to another either on foot (with or without a device) or in a wheelchair or geri chair.

ASSESSMENT/REASSESSMENT

The collection and interpretation of data. This data is gathered through record review, specific, direct observation, interview, and the administration of data collection procedures.

The requirement of an assessment/reassessment is indicated for several of the functional and/or service categories. Reference to an assessment does not mean the facility must develop a distinct assessment form for each category. Facilities should be encouraged to conduct a comprehensive assessment with emphasis given to the areas upon which resident programs or care plans will be based.

A reassessment does not require the completion of a new assessment duplicating the comprehensive assessment already conducted. A reassessment requires a focused review of the resident's current status, progress, the continual appropriateness of the program and/or care plan. The individual conducting the reassessment should document findings updating the initial assessment.

ASSISTANCE

Assistance refers to hands-on services by a staff member to help a resident do something such as dress, eat, etc.

AUGMENTATIVE COMMUNICATION SYSTEMS/DEVICES

Augmentative communication systems and devices encompass a broad range of unaided vs. aided communication systems. Examples of unaided modes of communications are gesturing, sign language, eye pointing and headnod/shake responses. Aided modes of communication may include use of an eye gaze communication board, or an electronic communication device that has speech output or a print tape.

BASE RATE SERVICES

Denotes minimum standard services covered in the base rate.

3-1-91

CERTIFIED OCCUPATIONAL THERAPIST ASSISTANT/LICENSED (COTA/L)

Has completed an occupational therapy program of at least two years in length leading to an associate degree, or its equivalent, approved by the Department of Professional Regulation (DPR); and has successfully completed the examination authorized by the DPR.

CLINICAL FELLOW (CFY)

The educational equivalent to a certified Speech-Language Pathologist/
Audiologist. This entry level professional is engaged in completion of the Clinical Fellowship Year/CFY required for certification as a Speech-Language Pathologist/Audiologist.

CLINICAL RECORD

Any document containing resident specific information. The clinical record includes information on the resident's current status, plans of care and resident's response to care. Flowsheets, treatment sheets and nurse's notes are all components of the clinical record. The clinical record is a permanent document.

DEPENDENT (TOTALLY)

Resident requires the activity of the given area of need to be administered and/or performed by the facility staff and the resident cannot perform the activity himself/herself.

FITNESS CARD

A card which includes individual resident data along with planned activities, frequency of activities, necessary monitoring, and documentation requirements.

FLOWSHEET

Specialized form designed for staff to record services and/or treatments delivered to residents on a regular basis. Flowsheets are a permanent part of the clinical record.

FLUIDO THERAPY

A multi-functional modality that simultaneously applies heat, massage, sensory stimulation and pressure oscillation through the use of pulverized corn husks. It is used to decrease pain and edema, increase range of motion and circulation and heal open or closed wounds. Unlike water the dry natural media does not irritate the skin or produce thermal shock.

INTERVENTION

Planned interactions requiring either hands-on or verbal action by a staff member. Actions are purposeful with the intent of altering or maintaining a resident's condition. Interventions are documented in resident's individualized plan of care.

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APPENDIX A: DEFINITIONS

KARDEX

A centralized source of information outlining the daily care needs of a resident. The entries made on this record are temporary and are updated as physician's orders or change in the resident's condition dictate. Its primary use is to provide a ready source of information for the direct care staff to use in planning for and prioritizing the resident's daily care.

LESS RESTRICTIVE ENVIRONMENT

Discharge to a less restrictive environment entails transfer of a resident from a skilled or intermediate care facility to a facility providing sheltered care or room and board, or discharge of a resident to home to independent living arrangement, or residential rehabilitation facility or an ICF-15.

MONITOR

Direct observation by staff of a resident for a specific purpose.

MONTHLY

Thirty (30) consecutive days.

NEED NOT MET

Objective criteria used to verify that services are not rendered or are not effective in meeting residents' needs.

NORMAL OPERATIONS OF FACILITY

Daily patterns of staff carrying out their prescribed duties or residents engaging in routine patterns of daily living.

OCCASIONAL

Action that does not occur in a pattern. For example, a resident is occasionally incontinent when he/she, due to medication, certain foods, excitement, etc., may have an accident. However, it is not a consistent pattern.

OCCUPATIONAL THERAPIST REGISTERED/LICENSED (OTR/L)

A graduate of an occupational therapy program of at least four years in length, leading to a baccalaureate degree, or its equivalent, approved by the DPR who has successfully completed the examination authorized by the DPR.

OFF-HOURS

Refers to medication prescribed by the physician to be given at times other than the facilities routine times for dispensing medication. Off-hour medications should be given for specific purposes (i.e. eye drops, antibiotics, etc.) and should be of a limited duration.

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PARAFFIN HEAT THERAPY

A paraffin bath is wax which has been completely melted to 126^{o}(F)-130^{o}(F). This treatment is used to apply heat uniformly to hand, foot or other body areas to relieve pain soreness and to relax muscle spasm. The heat relaxes the muscles and stimulates blood circulation.

PHYSICAL RESTRAINT

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Arm and leg restraints, hand mitts, soft ties or vests, wheelchair safety bars and gerichairs are considered physical restraints.

PHYSIATRIST

A physician who has specialized in the field of physical, occupational and speech therapies and all exercise and heat modalities for treating orthopedic, neurological and circulatory disturbances.

PHYSICAL THERAPIST (PT)

A graduate from a curriculum in physical therapy approved by the DPR and has passed an examination approved by the DPR to determine fitness for practice as a physical therapist.

PHYSICAL THERAPIST ASSISTANT (PTA)

A graduate from a two year college level program approved by the American Physical Therapy Association; or has two years of appropriate experience as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

PSYCHOTROPIC DRUGS

Any drugs which are used for anti-psychotic, anti-depressant, anti-manic, sedative-hypnotic, and/or anti-anxiety purposes and which are intended to control mood, mental status, or behavior of the resident.

QUALIFIED HEALTH PROFESSIONAL

An educator with a degree in education from an accredited program. A registered physical or occupational therapist. A physician licensed by the State of Illinois to practice medicine or osteopathy. A psychologist with a valid, current Illinois registration. A registered nurse with a valid, current Illinois registration. A registered speech pathologist or audiologist. A person with a Bachelor's Degree in one of the following areas of concentration: social work, applied sociology, applied psychology, or counseling and one year of health care experience in a health care setting. A therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification. A rehabilitation counselor who is certified by the Committee on Rehabilitation Counselor Certification.

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APPENDIX A: DEFINITIONS

QUALIFIED MENTAL HEALTH PROFESSIONAL

Qualified Mental health Professional (QMHP) a person who has at least one year of experience working directly with persons with mental illness and is one of the following: a doctor of medicine or osteopathy; a registered nurse; a psychologist with at least a master's degree in psychology from an accredited school; or an individual who holds at least a bachelor's degree in one of the following professional categories; an

occupational therapist or occupational therapy assistant certified by the American Occupational Therapy Association or other comparable body; a social worker with a bachelor's degree from a college or university or graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; a human services professional including, but not limited to: sociology, special education, rehabilitation counseling and psychology.

REASSESSMENT

See Assessment.

REHABILITATION NURSE

A registered professional nurse who has successfully completed a course approved by the Department of Public Health or documents at least 60 hours of classroom/laboratory training in restorative/rehabilitative nursing. This training must be documented by a transcript, certificate, diploma or other written documentation from an accredited school or recognized accrediting agency such as a state or national organization of nurses or a state licensing authority.

REHABILITATION SERVICES

Rehabilitation services are those related professional therapy services provided by or under the supervision of licensed, certified, or registered personnel. These services are specifically designed for an individual resident to improve the resident's functional abilities. Rehabilitation services must be ordered by the resident's physician. At a minimum these services must be provided by a duly qualified, certified nurse aide trained in a rehabilitation program approved by the Department of Public Aid. While there is no specific time limitation for their duration, improvement of the resident's condition must be evident in the resident's record.

RESTORATIVE SERVICES

Restorative services are those medical and nursing treatments provided either by or under the supervision of licensed personnel specifically required to maintain or improve a resident's functional condition or prevent further deterioration. These procedures should be reviewed by the facility's interdisciplinary team at the time of the care plan review and incorporated into the care plan. Services may include passive range of motion, palliative skin care, positioning, bowel and bladder retraining, ambulation, ADL retraining.

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APPENDIX A: DEFINITIONS

SKILLED SERVICES

Resident requires on a daily basis the direct observation, assistance, monitoring, or performance of nursing procedures by a licensed nurse or the direct supervision by a licensed nurse.

SUPERVISE

The process of overseeing or directing either staff in the care of the resident or the resident performing certain functional or medical tasks. In the case of residents, staff must be present either to instruct,

prompt, or to make sure the resident carries out a specific task in such a manner as to complete the task or avoid injury. In the case of staff, it is either direct supervision or the giving of detailed verbal or written instructions on how to carry out a specific procedure for or on a resident.

T.E.N.S. UNIT

Transcutaneous Electrical Nerve Stimulator (used strictly for pain control).

TRANSFER

The process of physically moving a resident from one place to another.

VERIFICATION OF LEVEL OF SERVICE

Activity by the Department's staff to verify that the level of service, as indicated by the facility, is both needed and received.

WHEELCHAIR CUFFS

Leather cuffs for quads who need traction on wheelchair rims; fingerless leather with an abrasive strip.

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APPENDIX B: OCCUPATIONAL THERAPY AND RELATED REHABILITATIVE SERVICES MEASUREMENT OF PROGRESS

A. Independent Living/Daily Skills

1. Physical Daily Living Skills (DLS). Measurable outcomes could include:
   - Decreasing assistance to perform a specific task component of a DLS - not necessarily decreased assistance needed in the entire category.
     Example: Resident is able to lift cup off table to drink (may remain dependent in feeding).

   Grading methods should show progression such as:
   - Unable to perform activity
   - Activity requires maximal physical assistance (resident attempts to help but completes no part of task).
   - Activity requires moderate physical assistance (resident able to do approximately 1/2 of activity).
   - Activity requires minimal physical assistance (resident able to do 3/4 of activity).
   - Activity requires supervision or verbal cues.
   - Activity is performed appropriately, safely, independently, and consistently in a reasonable amount of time.

2. Psychological/Emotional Daily Living Skills

   Measurable outcomes could include:
   - Decreasing exhibition of inappropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.
   - Increasing exhibition of appropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.
     Examples:
     - Decreases rocking to 25% of the day.
     - Verbalizes less than three (3) self depreciatory or destructive statements per day.
     - Contributes to group discussion 3 X in one hour session.

B. Sensorimotor Components

1. Measurable outcomes could include:
   * Reflex Integration.
     - Decreasing percentage of abnormal reflexes during occupational performance or task oriented activity.
   * Range of Motion.
     - Goniometrics showing an increase in range of motion.
   * Gross and Fine Coordination.
     - Effect of decreasing time on task completion, including percentage of task completed and/or number of repetitions completed. Effect of decreasing time on accuracy in task completion, including percentage of task completed and/or numbers of repetitions completed.
   * Strength and Endurance
     Measurable outcomes could include:*
     - Increasing dynamometer measurements

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APPENDIX B: OCCUPATIONAL THERAPY AND RELATED REHABILITATIVE SERVICES MEASUREMENT OF PROGRESS

- Increasing amount of weight, load, resistance
- Increasing number of repetitions
- Increasing duration of tasks
- Changes in heart rate, pulse rate, blood pressure, respirations per minute
- Manual muscle test

2. Sensory Integration

Sensory awareness, visual-spatial awareness, body integration, perception or differentiation of external and internal stimuli, as evidenced by objective measurements such as:*

- Number
- Duration
- Degree of performance
- Decreased error of performance

C. Cognitive Components

Measurable outcomes could include increased memory, problem solving, conceptualization, attention span as evidenced by objective measurements such as:

- Number
- Duration
- Degree of performance
- Decreased error of performance

D. Psycho/Social Components

Measurable outcomes could include:*

- Decreasing exhibition of inappropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.
- Increasing exhibition of appropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.

E. Therapeutic Adaptations

- Orthotics/prosthetics
- Assistive/adaptive equipment

Measurable outcomes could include:*

- Increased ROM
- Decreased contractures
- Prevention of further contractures
- Increased functional use
- Competency in use of equipment towards increased function

NOTE: Staff requirements include provision of equipment such as splints, prosthetics, and orthotic devices.

* Measure against a functional expectation considering the age and projected potential of each resident.3-1-91

APPENDIX B: PHYSICAL THERAPY AND RELATED REHABILITATIVE SERVICES MEASUREMENT OF PROGRESS

1. Goniometrics - measuring ROM in degrees

2. Manual muscle test (MMT) measure of muscle strength.

0	zero
1	trace
2	poor
3	fair
4	good
5	normal
+	greater than
-	less than

3. Increasing repetitions.

4. Increasing distance.

5. Balance measured by muscle strength: poor, fair, good, normal.

6. Changing gait deviation to improve functional ambulation.

7. Progression to a less restrictive assistive device.

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APPENDIX B: SPEECH LANGUAGE PATHOLOGY/AUDIOLOGY REHABILITATIVE SERVICES
MEASUREMENT OF PROGRESS

Types of modalities and activities which are typical for gaining functional abilities in geriatric population include but are not limited to:

AUDITORY COMPREHENSION

. comprehension and understanding of common, functional words
. comprehension and completion of directives
. comprehension and concepts of time, place, description, etc.
. comprehension and conversation, subtleties of language, meaning, etc.

SPEECH PRODUCTION

. improvement of oral-motor skills
. production of isolated sounds (phonemes)
. production of sounds in syllables, words, phrases, connected speech
. ability to use an appropriate vocal level with adequate breath support
. ability to utilize appropriate vocal quality for intelligible speech

EXPRESSION

. ability to name (imitatively-spontaneously) common, functional items
. ability to verbally produce meaningful and functional utterances (imitatively, spontaneously, self initiated)
. ability to express wants/needs, etc. through alternative means of communication (i.e. communication board, electronic communication device, etc.)

AURAL REHABILITATION

(Goals established only after an audiologic evaluation has been completed. A resident who exhibits a moderate to severe loss of hearing (i.e. 50dB SRT (Speech Reception Threshold) or greater loss in the better ear and/or an aided discrimination score of less than 70% accuracy in the aided ear) would be eligible for an Aural Rehabilitation Program).

. ability to achieve speech reading skills
. ability to discriminate words, sounds, etc. for effective comprehension
. ability of resident to achieve more independent operation of the hearing aid
. ability of resident to effectively and independently utilize environmental controls to compensate for their loss of hearing (i.e. eye contact, preferential seating, utilize better ear, etc.)

VOICE DISORDERS

. Achieve appropriate balance of oral/nasal resonance for effective communication
. Achieve use of proper vocal intensity, pitch or vocal quality for effective communication
. Achieve effective use of esophageal speech (for laryngectomized residents)
. Achieve use of appropriate augmentative system of communication when indicated (use of electrolarynx, etc., for laryngectomized resident)

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APPENDIX B: SPEECH LANGUAGE PATHOLOGY/AUDIOLOGY REHABILITATIVE SERVICES
MEASUREMENT OF PROGRESS

Progress is indicated when the following types of notation is observed in a resident's chart:

1. There is a decrease in the number of repetitions of directives or models required in order to achieve task completion.

2. There is a decrease in the number of cues required in order to achieve task completion. A cue is any verbal or non-verbal signal which stimulates task completion (i.e. residents with word finding problems may require cueing of an open ended sentence, residents with motor/speech problems may require a cue of oral configuration, etc.).

3. Tasks are completed in a more independent manner. Abilities to complete a skill move along a hierarchy from totally dependent to independent use of a skill:

    . imitative
    . cued
    . structured
    . non-structured
    . independent production

4. Tasks move in a hierarchy of the types of errors made in patient's/ resident's responses:

    . totally incorrect response
    . related error
    . a response requiring a repeat of directives or a cue
    . self corrected response
    . incomplete response
    . delayed response
    . complete independent immediate response

5. Tasks are completed in a hierarchy of complexity of resident's response:

    Verbal Expression

    . imitation of word
    . single word production from cue
    . independent production of single word
    . use of word in a structured phrase
    . use of word in a non-structured phrase
    . use of word in structured sentence
    . use of word in non-structured sentence
    . use in independent sentences in connected utterances
    . self initiation of thoughts, wants, needs, feelings, etc.

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APPENDIX B: SPEECH LANGUAGE PATHOLOGY/AUDIOLOGY REHABILITATIVE SERVICES MEASUREMENT OF PROGRESS

Motor-Speech

. imitation of oral postures
. imitation of phonemes in isolation
. imitation of phonemes in single syllable contexts
. spontaneous production in single syllable contexts
* . imitation in single words
. spontaneous production in single words
. imitation of the word in phrase
. spontaneous production of the word in phrase
. spontaneous self-initiated production in connected speech

Dysphagia

. able to effect a lip seal to hold bolus in oral cavity,
. able to maintain adequate jaw range of motion for mouth opening (up/down) and chewing (rotary), adequate tongue range of movement to: a) hold bolus; b) manipulate bolus, c) propel bolus into the pharynx,
. able to trigger a swallow reflex within one second,
. able to move food through the pharynx to the esophagus,
. able to protect the airway well enough to prevent aspiration during a swallow (maintain complete laryngeal closure),
. able to tolerate liquids by mouth for primary or supplemental nutrition,
. able to tolerate pureed consistencies by mouth for primary or supplemental nutrition,
. able to tolerate masticated consistencies by mouth for primary or supplemental nutrition,
. able to coordinate a cough to clear residue from the pharynx or larynx,
. able to learn the supraglottic swallow,
. able to learn to coordinate postural change and tongue and laryngeal involvement.

6. There is an increase in the percentage of correct responses observed in the resident's completion of tasks.

7. There is an increase in the resident's level of functioning as demonstrated by formal testing (i.e. higher verbal scores for expressive language disorders, improved scores in tests of speech reading for aural rehabilitation patients, etc.)

8. Resident's skills become more functional in nature and are generalized and carried over to contexts outside of the therapeutic environment.